	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL080003	B. WING		12/22/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
KANNON	CDEEK ASSISTED I IVIN	1808 N C	CANNON BOULVAR	RD		
KANNON	CREEK ASSISTED LIVIN	KANNAI	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 000	Initial Comments		D 000			
		sure Section conducted an survey on 12/17/14 to 4.				
D 074	10A NCAC 13F .0306 Furnishings	(a)(1) Housekeeping And	D 074			
	10A NCAC 13F .0306 Furnishings (a) Adult care homes (1) have walls, ceiling coverings kept clean a	shall: gs, and floors or floor				
	failed to assure ceiling	as evidenced by: s and interviews, the facility gs, walls, and floors were air in 2 residents' rooms				
	The findings are:					
	12/17/14 at 10:20 am am revealed: - Three residents residents residents residents residents residents residents repaired with span and the east pots repaired with span and the resident residen	at side of the room had 62 backling compound. side of the room had 23 backling compound. de of room toward the original inches by 14 inches and compound revealing and. de of room toward the barea 14 inches by 18 inches and compound revealing				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING	B. WING		R 2/ <b>22/2014</b>
NAME OF B	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E ZIR CODE	12	12212014
NAME OF P	ROVIDER OR SUPPLIER		ANNON BOULVA			
KANNON	CREEK ASSISTED LIVIN	G	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 074	Continued From page	e 1	D 074			
		ceiling running from the end ne east wall (about 4 feet).				
		n, and attempted interview dents of Room 103 were able information.				
	months.  - He did not have an a maintenance.  - He was aware some need of painting.  - He had not done the	revealed: g at the facility for about 2				
	patched and unpainte - He was not aware R exposed areas and a - He had been doing painting had been foo hallways and common - He had a long list of	ed for at least 2 months.  Room 103 had 2 large  crack in the ceiling.  painting in the facility but his  cused primarily on the				
	such as replacing and -She was working wit	d: e process of "fixing things"				
	Refer to review of the report dated 12/02/14	local environmental health				
		/17/14 during the initial tour am of resident room #115				

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STATE FORM 03GX11 If continuation sheet 2 of 159

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		12/2	2/2014
	ROVIDER OR SUPPLIER  CREEK ASSISTED LIVIN	1808 N CAI	RESS, CITY, STANON BOULVALIS, NC 28083	ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 074	door, approximately 2 bottom of the wall up -The baseboard was the wall approximately paint was missing from Interview on 12/17/14 revealed: -He had lived in the farmissing from the wall he had lived at the fact Interview on 12/19/14 Maintenance Director -He had been employ monthsHe was aware the wabaseboard was missing -He said the residents the wall which knocked baseboard offHe said he was plant the baseboard as soot Refer to review of the report dated 12/02/14 revea -A facility sanitation gone demerit was deand CeilingsUnder additional condocumentation to pain	and from an area near the and the stoward the middle of wall. It was a special to the facility for 15 months. It is at 2:45 pm with the revealed: It was not painted and the fing in room #115. It is a run the wheelchairs into the paint and the ming to repair the wall and the man as possible.  I local environmental health report led: rade of 95.5. Iducted under Floors, Walls	D 074			

Division of Health Service Regulation

STATE FORM 6899 O3GX11 If continuation sheet 3 of 159

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	<del></del>		
		HAL080003	B. WING		12/2	2/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	ANNON BOULV			
		KANNAP	OLIS, NC 28083	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
D 076	Continued From page	3	D 076			
D 076	10A NCAC 13F .0306 Furnishings	S(a)(3) Housekeeping And	D 076			
	10A NCAC 13F .0306 Furnishings (a) Adult care homes (3) have furniture clear This Rule shall apply facilities.	shall: an and in good repair;				
		nd observation the facility air for a resident in room				
	The findings are:					
	revealed: -Three residents lived: -One of the residents because he was unabeThere was only one of the chair was a tander of the chair was a tande	was not interviewable ble to verbally respond. chair in the room. leather wide high back. shout the chair were bed. visible through the cracks,				
	revealed: -The chair had been i "long-time." -The chair was mainly could not talk.	y used by the resident who ident sat on their bed.  at 11:40 am with the				

Division of Health Service Regulation

-The facility was in the process of "fixing things"

STATE FORM 6899 O3GX11 If continuation sheet 4 of 159

	OF DEFICIENCIES OF CORRECTION	,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL080003	B. WING		R 12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	1808 N CA	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	KANNAPO	DLIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
D 076	Continued From page	e 4	D 076		
	such as replacing and	d repairing furniture. h the Maintenance Director			
D 079	10A NCAC 13F .0306 Furnishings	s(a)(5) Housekeeping and	D 079		
	10A NCAC 13F .0306 Furnishings (a) Adult care homes (5) be maintained in a orderly manner, free of hazards; This Rule shall apply facilities.	shall an uncluttered, clean and of all obstructions and			
	failed to assure the 30	as evidenced by: n and interview, the facility 00 hallway was maintained ner free of hazards and			
	The findings are:				
	from 8:40 am to 9:50 -The 300 hallway had Service Manager's (F office, maintenance o -2 rooms were occupi -The following items v along both sides of th	access to the kitchen, Food SM) office, Activity person ffice and 9 resident rooms. led by residents. were observed in the hallway e 300 hallway: feet stacked on top of each			

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STATE FORM 03GX11 If continuation sheet 5 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL080003	B. WING		12	R 2/ <b>22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE,	ZIP CODE		
		1808 N C	ANNON BOULVAR	D		
KANNON	CREEK ASSISTED LIVIN	G KANNAP	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 079	Continued From page	e 5	D 079			
	-2 utility carts; one ca blower, and many oth -Sitting on the floor w blower; 2 motorized w cart with three shelve -A 6.5 feet cart with s	rt had an industrial size air er items. as another industrial size air wheelchair; hoyer lift; and a				
	1	ew, observation and 4 with the resident residing etermined the resident was				
	in room 302 revealed -Things were always					
	resident in room 302 -The items in the hall -Staff put them there.	way were not her fault. ner, she walked through				
	revealed: -The hallway was use the items were waiting rooms (not the reside hallway)Two more residents they were out of the fall Interview on 12/17/14 care aide (PCA) reveal	at 9:05 am with a personal				

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STATE FORM 6899 O3GX11 If continuation sheet 6 of 159

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		R <b>12/22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	,
		1808 N CAI	NNON BOULV		
KANNON	CREEK ASSISTED LIVIN	KANNAPO	LIS, NC 28083	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 079	the hallway for storag lived on the hallway.  -The items in the hall the three residents' mallway.  -The two residents in and able to go throug assistance.  -The resident in room he was sometimes corequired staff assistant dressed.  -There were some dastaff help and was abhimself around the fall linterview on 12/17/14 Administrator reveale. She was unaware of the 300 hallway.  -She had talked with storing items in the haw alking spaces of the hallway.	ne maintenance person used e because few residents way did not appear to hinder rovement that lived on the room 301 were ambulatory hout the facility without staff 301 was hard of hearing, onfused and some days noce to ambulate and get ys the resident did not need le to ambulate and wheel cility.  e at 11:50 am with the d: the items being stored on	D 079		
	will check weekly to e on the hallway.	ensure no items were stored			
	stands and fans on th	*** ** ** *** ****			
D 089	10A NCAC 13F .0306 Furnishings	6(b)(3) Housekeeping And	D 089		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		HAL080003	B. WING		R <b>12/22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	1808 N CA	NNON BOULV	ARD	
		KANNAPO	LIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 089	Continued From page	e 7	D 089		
D 089	10A NCAC 13F .0306 Furnishings (b) Each bedroom sh furnishings in good re resident: (3) chest of drawers provided as built-ins, drawers or double drowers or double drowers or double drowers.  This Rule is not met Based on observation failed to assure chest in good repair for 4 of #202, #208, and #21  The findings are:  A. Observation during between 8:50 am to 9-Room #208, three reside of the room.  -One chest of drawer on the top drawer.  -There was an exposileft of the drawer when to be.  -One resident in the ridifficulty trying to pull fingers.	or bureau when not or a double chest of esser for two residents; to new and existing  as evidenced by: as, and interviews, the facility of drawers were clean and 4 residents' rooms (#103, 1).	D 088		
		nost falling out of the chest of			
	revealed: -The chest of drawers	at 9:20 am with a resident s had been like it was today the room (a few weeks			

Division of Health Service Regulation

STATE FORM 6899 O3GX11 If continuation sheet 8 of 159

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL080003	B. WING		12/22/2014
					12/22/2011
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,	
KANNON	CREEK ASSISTED LIVIN	G	ANNON BOULV		
		KANNAP	DLIS, NC 28083	3	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
D 089	Continued From page	e 8	D 089		
	ago).				
	• ,	s had never had any handles			
	on it.	,, ,, ,, ,, ,			
	-It would make it easi	er to open if the top drawer			
		ause he stored his clothes			
	in that drawer.				
	•	awers and his roommate			
	used the bottom 2 dra	awers.			
	Interview on 12/17/14	at 9:25 am with the			
	Maintenance Director				
	-The chest of drawers	s did have handles on it			
	yesterday (12/16/14).				
	· ·	e handles "all the time".			
		stantly pulling the handles			
	off.				
	Refer to the local env report dated 12/02/14	ironmental health inspection			
	Refer to interview on	12/19/14 at 4:10 pm with a			
	medication aide.				
	Refer to interview on	12/22/14 at 11:22 am with			
	the Maintenance Dire				
	Refer to interview on	12/22/14 at 11:40 am with			
	the Administrator.				
	P. Observation on 12	/10/14 at 3:00 pm of room			
	#202 revealed:	/19/14 at 3:00 pm of room			
	-Three residents residents	ded in the room.			
		est of drawers in the room.			
		s was missing 2 drawers.			
	-One chest of drawers	s was missing 1 drawer.			
	•	ers of the chest of drawers			
	were broken and posi	tioned at an angle.			
	Interview on 12/19/14	at 3:05 pm with a resident			

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revealed:

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILBING.			
		HAL080003	B. WING		R <b>12/22</b> /2	2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV			
		KANNAPO	DLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 089	Continued From page	9	D 089			
	-The drawers had alwappeared today (12/1-She had to share a continuous the roommates becauted would be great to had asked the policetor 6 months agand he told her he wonever fixed it.  Refer to the local environmedication aide.  Refer to interview on the Maintenance Director of to share a continuous to shar	vays been this way as they 9/14). Chest of drawers with one of use of the missing drawers. In ave her own chest of drawer and me to store her clothing. The orevious Maintenance to to fix the chest of drawers build add it to his list, but he dironmental health inspection 12/19/14 at 4:10 pm with a 12/22/14 at 11:22 am with				
	#211 revealed: -There were three cheThree residents residents residents residents residents residents residents.	/19/14 at 3:10 pm of room  est of drawers in the room.  ded in the room.  le chest of drawers was d in the chest of drawers at				
	revealed: -The chest of drawers that".					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			, 551251110.			
		HAL080003	B. WING		R <b>12/22/2</b> 0	014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	ANNON BOULV OLIS, NC 28083			
0/4) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	ı l	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) OMPLETE DATE
D 089	Continued From page	e 10	D 089			
	Refer to the local env report dated 12/02/14	ironmental health inspection				
	Refer to interview on medication aide.	12/19/14 at 4:10 pm with a				
	Refer to interview on the Maintenance Dire	12/22/14 at 11:22 am with ector.				
	Refer to interview on the Administrator.	12/22/14 at 11:40 am with				
	Room #103 revealed - Three residents resi - Three chest of draw on the east wall of the - One chest of drawer the chest missing or p exposed rough and u and 2 drawers that die - One chest of drawer the chest missing or p exposed rough and u drawer missing a pull did not properly slide - One chest of drawer the chest missing or p exposed rough and u drawer missing a pull did not properly slide - The bedside table for	ded in Room #103.  ers with 4 drawers located eroom.  rs had the part of the top of beeling veneer which on the period out.  rs had the part of the top of beeling veneer which on the period out.  rs had the part of the top of beeling veneer which out.  rs had the part of the top of beeling veneer which out.  rs had the part of the top of beeling veneer which out.  rs had the part of the top of beeling veneer which on the period of beeling veneer which on the period of beeling veneer which on the period of the top of beeling veneer which on the period of the top of beeling veneer which on the period of the top of beeling veneer which on the period of the top of the period of the period of the top of the top of the period of the per				
	Refer to review of the inspection report date	e local environmental health ed 12/02/14.				
	Refer to interview on	12/19/14 at 4:10 pm with a				

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medication aide.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			' '	(X2) MULTIPLE CONSTRUCTION	
7.1.12 . 2.1.1		.5,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	A. BUILDING: _		COMPLETED
		1141 000003	B. WING		R
		HAL080003			12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	G	ANNON BOULV		
			OLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
D 089	Continued From page	e 11	D 089		
	the Maintenance Dire	12/22/14 at 11:22 am with actor. 12/22/14 at 11:40 am with			
	Review of the local et inspection report date -A facility sanitation g -Two demerits deduc Patient Contact Items -Under additional condocumentation drawe issued dressersTops of chest of drawin bad repairThe finish (on chest damaged leaving a stand absorbent.  Interview on 12/19/14 medication aide (MA)	ed 12/02/14 revealed: rade of 95.5. ted under Furnishings and s. nments included ers were missing from facility wers and night stands were of drawers) had been urface not easily cleanable at 4:10 pm with a revealed:			
	like missing drawer farunless a resident con known anything about or if there were needer. There had been no rany concerns or issue Interview on 12/22/14 Maintenance Director. He had been working months.  He did not have an amaintenance.  He was aware some which needed replaci	mplained, she would not any of the residents' rooms ed repairs. esident complaints about es with their rooms.  At 11:22 am with the revealed: g at the facility for about 2 assistant to help with e residents had furniture			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL080003	B. WING		12/22/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		1808 N CA	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	IG KANNAPO	LIS, NC 28083	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 089	9 Continued From page 12		D 089		
	were damaged from r (like beverage cups) or resulting in water dam - The facility had been furniture as the budge Interview on 12/22/14 Administrator reveale -The facility was in the such as replacing and -She was working wit	residents placing wet items on the top of the chest nage to the tops. In replacing residents' et allowed.  If at 11:40 am with the d: If a process of "fixing things"			
D 091	10A NCAC 13F .0306 Furnishings	S(b)(5)(6) Housekeeping And	D 091		
	resident: (5) a minimum of one or straight, arm or wit resident), high enoug (6) additional chairs a by visitors; This Rule shall apply facilities.  This Rule is not met Based on observation failed to furnish one or resident in 10 of 19 m #107, #112, #120, #2 #211, and #212) and	nall have the following epair and clean for each comfortable chair (rocker hout arms, as preferred by h from floor for easy rising; available, as needed, for use to new and existing			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL080003	B. WING		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	ATE, ZIP CODE	
	00551/ 40010550 I II/II	1808 N CA	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	IG KANNAPC	LIS, NC 28083	3	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE DATE
D 091	091 Continued From page 13		D 091		
	A Observations on 1	2/19/14 between 3:00 pm to			
		Hallway of the facility (rooms			
	201 to 302) revealed:				
		chairs and three residents.			
		chairs and three residents.			
	-Room #204 had no d	chairs and three residents.			
	-Room #205 had no d	chairs and three residents.			
	-Room #206 had one	folding chair and two			
	residents.				
	-Room #207 had no d	chairs and three residents.			
	-Room #208 had no d	chairs and three residents.			
	-Room #209 had no o	chairs and three residents.			
	-Room #210 had no o	chairs and three residents.			
		chairs and three residents.			
		chairs and two residents.			
	-Room #302 had no d	chairs and two residents.			
	Observations on 12/1	9/14 between 3:30 pm to			
		Hallway of the facility (rooms			
	101 to 122) revealed:				
	,	chairs and two residents.			
	-Room #103 had no d	chairs and three residents.			
	-Room #104 had no d	chairs and two residents.			
	-Room #107 had no d	chairs and two residents.			
	-Room #112 had 1 ch	nair and three residents.			
	-Room #116 had no d	chairs and two residents.			
		chairs and two residents.			
	-Room #120 had no o	chairs and two residents.			
	Interview on 12/19/14	at 3:30 pm with a personal			
	care aide (PCA) reve	•			
		acility for a few months.			
	-The rooms appeared				
		ot notice if there were chairs			
	in the residents' room				
	-She rarely went into	the residents' rooms,			
	because most of the	residents were "pretty"			
	independent.				
	-As far as she knew,				
	complained about not	t having chairs in their			

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STATE FORM 6899 O3GX11 If continuation sheet 14 of 159

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING	B. WING		2/2014
	ROVIDER OR SUPPLIER  CREEK ASSISTED LIVIN	1808 N CA	DRESS, CITY, STA INNON BOULVA DLIS, NC 28083	ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 091	revealed: -It would be nice to hat the roomThe resident was not could be requestedThe room had been the room about 2 weel Interview on 12/19/14 medication aide (MA) -She had not noticed chairs the residents' refundess a resident contains and the roomsThere had been no refund any concerns or issued Interview on 12/22/14 Maintenance Directores and the repaired of monthsHe had been given and repair furniture in time to get things don't interview on 12/22/14 Administrator revealeThe facility was in the such as replacing and reposited on the repaired of the	at 3:40 pm with a resident ave a chair to sit in while in t aware a chair in the room like this" since moving into eks ago.  at 4:10 pm with a revealed: anything about chairs or no ooms. mplained, she would not any of the residents ' esident complaints about es with their rooms.  at 11:20 am with revealed: g at the facility for a couple long list of things that d and/or replaced. what he could do" to replace cluding chairs, but it took e.  at 11:40 am with the d: e process of "fixing things"	D 091			

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resident revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	COMPLETED	
					R
		HAL080003	B. WING		12/22/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		1808 N CA	NNON BOULV		
KANNON	CREEK ASSISTED LIVIN	IG .	DLIS, NC 28083		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 091	D 091 Continued From page 15		D 091		
	chairs in their roomHe did not care if the	d if they had or did not have ere were no chairs in his eays went to the activity room			
	Interview on 12/19/2014 at 3:45 pm with a resident revealed: -She had never had a chair in her room -She had not told the staff because she could ask for a chair.				
	resident at a local gai	ner room was bought by the rage sale. to have a comfortable chair			
	she began employme -She heard no compl	PCA) revealed: ed chairs in the rooms since			
D 093	10A NCAC 13F .0306 Furnishings	6(b)(8) Housekeeping And	D 093		
	furnishings in good re resident: (8) a light overhead of reach of person lying	nall have the following epair and clean for each of bed with a switch within on bed; or a lamp. The light um of 30 foot-candle power ding.			

Division of Health Service Regulation

STATE FORM 6899 O3GX11 If continuation sheet 16 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		OOM! LETED	
		HAL080003	B. WING		R <b>12/22/2014</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N CA	NNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	KANNAPO	LIS, NC 28083	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 093	093 Continued From page 16		D 093			
	facilities.					
	iaciiiles.					
	failed to assure there bed with a switch with bed or a bedside lam (rooms #102, #107, # #212) and 7 of 16 wo #104, #116, #119, #2	ns and interviews, the facility was a light overhead of the nin reach of residents lying in p for 7 of 19 men's rooms #205, #208, # 210, #211, and men's rooms (Rooms #103,				
	The findings are:					
	3:30 pm on the 200 H 201 to 212) revealed: -An overhead ceiling	9/14 between 3:00 pm to dallway of the facility (rooms light with the on/off switch ne entrance door of each				
	residents while lying i	uld not be accessed by the in bed. Dedside lamps and three				
	residents.	occorde rampo ana unice				
	residentsRoom #206 had one	bedside lamps and three				
	one resident) and two -Room #207 had no bresidents.	o residents. Dedside lamps and three				
	-Room #208 had no bresidents.	pedside lamps and three				
	<ul> <li>-Room #210 had no to residents.</li> </ul>	pedside lamps and three				
	-Room #211 had no b residents. -Room #212 had one	bedside lamps and three				
	one resident) and two	residents.				
		9/14 between 3:30 pm to Hallway of the facility (rooms				

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STATE FORM 6899 O3GX11 If continuation sheet 17 of 159

Division of	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
						D
		HAL080003	B. WING		I	R 22/2044
		HALU60003			1 12/	22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
KANNON	ODEEN ACCIOTED I IVIN	1808 N C	ANNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	KANNAP	OLIS, NC 2808:	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	CTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE	DATE
			+	1		
D 093	O 093 Continued From page 17					
	101 to 122) revealed:					
		light with the on/off switch				
		ne entrance door of each				
		le entrance door or each				
roomThe on/off switch could not be accessed by the						
	residents while lying i	<u> </u>				
	, ,	pedside lamps and two				
	residents.	<b>,</b>				
		pedside lamps and three				
	residents.					
	-Room #104 had no b	pedside lamps and two				
	residents.					
	-Room #116 had no b	pedside lamps and two				
	residents.					
		pedside lamps and two				
	residents.					
	linta milinua na 40/40/44	1 -t 0:00				
		at 3:30 pm with a personal				
	care aide (PCA) reve- -The rooms appeared					
		ed the residents did have to				
		the overhead light on and				
	off	the overhead light on and				
	-As far as she knew,	residents had not				
		t having bedside lamps in				
	their rooms.					
	Interview on 12/19/14	at 3:40 pm with a resident				
	revealed:					
		today as it did when the				
	resident moved in a fe					
		aff for a bedside lamp.				
		could request a bedside				
	lamp.					
		ave a bedside lamp so the				
		eve to get out of bed to turn				
	the ceiling light on an	u oii.				
	Interview on 12/19/14	at 4:10 pm with a				
			1			1

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medication aide (MA) revealed:

STATE FORM 6899 O3GX11 If continuation sheet 18 of 159

DIVISION	n nealth Service Regu	iialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					F	₹
		HAL080003	B. WING		12/2	2/2014
					•	-
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		1808 N C	ANNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	IG Kannap	OLIS, NC 2808:	3		
						1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
TAG	REGOLATORT ORT	EGG IDEIVIII TIIVO IIVI ORWATION)	TAG	DEFICIENCY)	WATE.	
				,		
D 093	D 093 Continued From page 18		D 093			
	oonaou i ro pagi					
	-She had not noticed	anything about the lights or				
	lamps the residents' r	rooms.				
	•	mplained, she would not				
	know anything about					
	rooms.	arry or the redicerno				
		cooldant complaints about				
		resident complaints about				
	any concerns or issue	es with their rooms.				
	Interview on 12/22/14	at 11:20 am with				
	Maintenance Director	r revealed:				
	-He had been working	g at the facility for a couple				
	of months.	-				
	-He had been given a	a long list of things that				
	needed to be repaired					
	•	what he could do" to replace				
	_					
	-	icluding bedside lamps, but				
	it took time to get thin	igs done.				
	Interview on 12/22/14	at 11:40 am with the				
	Administrator reveale	ed:				
	-The facility was in the	e process of "fixing things"				
	such as replacing and	d repairing furniture.				
		th the Maintenance Director				
		ne, but it "takes time".				
	to try to get triings do	ne, but it takes time .				
	Interview on 12/10/20	014 at 2:25pm with a				
	Interview on 12/19/2	o 14 at 3.35pm with a				
	resident revealed:					
	-He had never notice	d they had no lamps in their				
	room.					
	-He did not care if the	ere were no lamps in his				
	room.					
	Interview on 12/19/20	014 at 3:45pm with a resident				
	revealed:	,				
		ever had a lamp in her room.				
		f because she was unaware				
	that she could ask for	•				
		ally like to have a bedside				
	lamp in her room and	l it would help when she was				

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STATE FORM 6899 O3GX11 If continuation sheet 19 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL080003	B. WING		R <b>12/22/2014</b>	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KANNON	CDEEK ASSISTED I IVIN	1808 N CA	NNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	KANNAPO	LIS, NC 28083	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 093	Continued From page	e 19	D 093			
	reading her books.					
	revealed: -Stated she would rearoom.	ally like to have a lamp in her because she was unaware edside lamp.				
D 107	10A NCAC 13F .0311	(b)(1) Other Requirements	D 107			
	maintain 75 degrees winter design condition following shall apply to appliances.  (1) Built-in electric herinstalled or protected to residents and room	heating system sufficient to F (24 degrees C) under ons. In addition, the to heaters and cooking eaters, if used, shall be so as to avoid burn hazards				
	failed to ensure built-i conditioning units in r installed or protected	ns and interviews, the facility in electric heating/air				
	The findings are:					
		9/14 between 3:30 pm to Hallway of the facility (rooms				
	A. In room #116, the l	built-in heating/air located under the window				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED		
		HAL080003	B. WING		12	R 2/ <b>22/2014</b>
	ROVIDER OR SUPPLIER  CREEK ASSISTED LIVIN	1808 N C	DDRESS, CITY, STATE CANNON BOULVAI POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 107	front cover.  -The built-in heating/a slanted top cover with -The temperature was -There were exposed right side of the built-i unit.  -There were exposed side of the unit just be coils.  Interview on 12/19/14 revealed:  -The heating/air cond looked like that" since several months ago.  -The unit "worked fine anything to staff about cover.  Refer to interview on Maintenance Director Refer to review of an from the Administrato the corporate office.  Refer to interview on medication aide.  Refer to interview on the Administrator.  B. In room #121, the conditioning unit was on the south side of the place on the wall by granter was visible granter.	air conditioning unit had a digital controls. It is set on 70 degrees. It copper coils on the left and in heating/air conditioning electrical wiring on the right elow the exposed copper at 3:48 pm with a resident elow the exposed copper at 3:48 pm with a resident elow the into the room at the unit missing the front at 12/18/14 at 9:15 am with the e-mail correspondence on 12/18/14 at 9:33 am to a 12/19/14 at 4:10 pm with a 12/19/14 at 11:40 am wit	D 107			

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STATEMENT OF DEFICIENC AND PLAN OF CORRECTIO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		HAL080003	B. WING			R / <b>22/2014</b>
NAME OF PROVIDER OR S	UPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
KANNON CREEK ACC	CTED LIVIN		ANNON BOULV	ARD		
KANNON CREEK ASSI	2 I ED LIVIN	KANNAP	OLIS, NC 28083	3		
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 107 Continued	From page	21	D 107			
was 8 inch -The gray unit to the heating/air -On the bo opening co outside of coming thr  Interview of revealed: -The heatin for the wal maintenan the framew -The unit w problem w works good -Sometime in the sum come and bugs"The reside heating/air worked fine  Refer to in Maintenan  Refer to re the Admini corporate of  Refer to in medication	es wide. duct tape a framework conditionir ttom of the overed over the building ough the 1 on 12/19/14 ong/air cond way it was ong/air cond offramework coe director vorke to "m vorked fine tith the way d". es bugs wo mertime, b "spray" eve ent had not conditionir e just the w terview on ce Director view of an estrator on office. terview on a aide.	appeared to attach the wall built into the wall to hold the ang unit.  I unit, there was a 1 inch or by gray duct tape and the gray sunlight was observed inch opening.  I at 11:40 am with a resident ditioning unit had been duct today for about 4 years. itioning unit was too small ks, so the previous had duct taped the unit into ake it fit".  I and the resident had no it appeared, "as long as it uld come in around the unit ut the exterminator would ery month to keep "down the at told the staff about the ang unit because the unit way it was.  I 2/18/14 at 9:15 am with the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING	<del></del>		•
	HAL080003	B. WING		12/2	2/2014
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON CREEK ASSISTED LIVIN	G	ANNON BOULVA			
	KANNAPO	OLIS, NC 28083			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 107 Continued From page	22	D 107			
#212 revealed: -Heating wall unit had the entire edges of the pieceThe control part of the a secured slanted cov  Interview on 12/17/20 resident revealed: -Heating wall unit had "the state came in the year ago." -He had to use a pend the controls to adjust to the controls are cover -He has to open the w it got too warm inside -The previous Mainter way just to get by"He has informed the Director about the cor conditioner unitHas told the Administ condition and she had  Interview on 12/18/20 Maintenance Director room #206 complaine 12/08/2014 about his condition.  Interview on 12/18/20 Administrator revealed -She thought the unit	I been in this condition since a last time, which was over a cil in order to reach and set the temperature because red by a grill.  Vindow sometimes because his room.  Inance Director "rigged it this current Maintenance andition of the heater/air trator about the unit's dobserved it in his room.  I 4 at 9:10 am with the revealed the resident in red to him during the week of heating wall unit's current.				

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-When asked if she ordered the parts on

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL080003	B. WING		12	R 2/ <b>22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N C	CANNON BOULVAR	RD		
KANNON	CREEK ASSISTED EIVII	KANNAI	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 107	D 107 Continued From page 23		D 107			
	yesterday" (12/17/14 -The Resident in room	ed "Oh, I did order some ). m #206 never made her dition or complained to her				
	Personal Care Aide (revealed: -She had reported th the previous Mainten 6 months but did not	2014 at 4:00 pm with a (PCA) concerning room #206 e condition of the wall unit to cance Director within the last follow up on it.				
	Refer to interview on Maintenance Directo	12/18/14 at 9:15 am with the r.				
		e-mail correspondence from 12/18/14 at 9:33 am to the				
	Refer to interview on Medication Aide.	12/19/14 at 4:10 pm with a				
	Refer to interview on 12/22/14 at 11:40 am with the Adminsitrator.					
	units in the building r -He had been workin get several replaced -He had gotten whate "quick fix" them until -The parts were orde	r revealed: several heater/air conditioner needed repair. g with the corporate office to throughout the building. ever he could get in order to				
	Review of an e-mail	correspondence from the				

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	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL080003	B. WING		12	R 2/ <b>22/2014</b>
	ROVIDER OR SUPPLIER  CREEK ASSISTED LIVIN	1808 N (	ADDRESS, CITY, STATE CANNON BOULVAR POLIS, NC 28083	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 107	corporate office reveal -Need 4 retro (model conditioner units) with controls.  -"This is the model the existing wall sleeve".  Interview on 12/19/14 Medication Aide (MA) -She had not noticed residents' rooms.  -Unless a resident coknow anything about rooms.  -There had been no rany concerns or issued interview on 12/22/14 Administrator revealed. The facility was in the such as replacing and -She was working with controls.	8/14 at 9:33 am to the aled: number for heater/air no cover, left hand plug and at fits correctly for the  at 4:10 pm with a prevealed: anything about any of the amplained, she would not any of the residents ' esident complaints about es with their rooms.  at 11:40 am with the d: e process of "fixing things"	D 107			
D 150	And Competency  10A NCAC 13F .0501 And Competency  (a) An adult care hor who provide or direct provide personal care complete an 80-hour competency evaluation the Department. Direct provide personal care competency evaluation.	Personal Care Training  Personal Care Training  ne shall assure that staff y supervise staff who e to residents successfully personal care training and on program established by ectly supervise means being to oversee or direct the	D 150			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDIEAN	or contribution	IDENTIFICATION NOWIDER.	A. BUILDING: _			
		HAL080003	B. WING		R 12/22/2	2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV			
		KANNAPO	LIS, NC 28083	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE 0	(X5) COMPLETE DATE
D 150	Continued From page	25	D 150			
נו פו ע	80-hour training and oprogram are available mailing by contacting Services, Adult Care Mail Service Center, I (b) The facility shall a in Paragraph (a) of the completed within six in hired after September the successful completed and competency eval maintained in the facility failed to assure B) successfully compound Care Training and Coprogram within six modern that the facility failed to assure B) successfully compound the findings are:  Review of Staff B's perestaff B was hired on Staff B was hired as aide/supervisor.  Documentation of mediated 6/24/10.  Documentation Staff aide Clinical Skills Compound Care Training Care	competency evaluation at the cost of printing and the Division of Facility Licensure Section, 2708 Raleigh, NC 27699-2708. Assure that training specified is Rule is successfully months after hiring for staff r 1, 2003. Documentation of action of the 80-hour training uation program shall be lity and available for review.  as evidenced by: and record reviews, the at 1 of 7 sampled staff (Staff leted an 80-hour Personal impetency Evaluation bonths of hire.  Assured the Medication and record reviews and record reviews and record reviews, the at 1 of 7 sampled staff (Staff leted an 80-hour Personal impetency Evaluation bonths of hire.  Assured the Medication and the completed the Medication and the staff B had completed and 19/20/11 of a Nurse Aide tion from another state was not listed on the CNA				
	,	at 9:00 am with Staff B				
	revealed:					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _	A. BUILDING:	
		HAL080003	B. WING		R 12/22/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	1808 N CA	NNON BOULV	ARD	
- IVAINION	OKEEK AGGIOTED EIVIN	KANNAPO	LIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 150	Continued From page	26	D 150		
	-She had been employearsShe had not complete. She had attended "C 20 years agoShe could not product had completed "CNA" burned up" in a house. She could not contact attended to request p "CNA" course because burned downHer work duties inclumedications, and on control residents with bathing.  Interview on 12/22/14 Administrator reveale. She had "ran" a verification and the NA Registry in the She did not know Stana Registry for anothes. She was unable to won NA trainingStaff B would not be as a supervisor or PC completed Personal C-She had scheduled Stana supervisor or PC completed Personal C-She had sc	ed Personal Care Training. Sertified Nurse Aide" school  ce a certificate to show she school" because it had e fire.  ct the "CNA school" she roof of completion of the se the school had also  aded administering occasion she did assist g, grooming and dressing.  at 9:15 am with the d:  fication from the state Staff B thought she was listed on at state.  aff B was not listed on the er state.  erify Staff B had completed  able to perform the duties of A duties until Staff B  Care Training.  Staff B to begin Personnel			
D 183	Care Training next we 10A NCAC 13F .0603 Facilities with a Capa	s(a) Management of	D 183		
	with a Capacity or Ce Residents (a) An adult care hon	Management of Facilities nsus of 81 or More ne with a capacity or census ts shall be under the direct			

Division of Health Service Regulation

STATE FORM 6899 O3GX11 If continuation sheet 27 of 159

Division of	<u>of Health Service Regu</u>	ılation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					-	,
		HAL090003	B. WING		F	
		HAL080003			12/2	22/2014
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1808 N CA	ANNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	IG KANNAPO	DLIS, NC 28083	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
			1	DEFICIENCY)		
D 183	Continued From page	e 27	D 183			
	control of an administ					
		peration, administration,				
		pervision of the facility on a				
		ure that all care and services				
		ded in accordance with all				
	• •	e and federal regulations and				
		rator shall be on duty in the				
		nours per day, five days per				
		erve simultaneously as a				
	=	upervisor or other staff to				
	• .	ments while on duty as an				
		n administrator for another				
		ept as follows. If there is				
		on a contiguous parcel of				
	land or campus setting	-				
		he facilities is 200 beds or				
	_	ne administrator on duty for				
		e campus. The administrator				
		aneously as a personal care				
		s campus setting. For				
	staffing chart, see Ru	ıle .0606 of this Subchapter.				
	TI: D					
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
		ns, interviews and record				
		ailed to assure all care and				
	services were provide					
		nce with all applicable local,				
	state, and federal reg	• •				
	The findings are:	,				
	•	tions and interviews, the				
		e ceilings, walls, and floors				
	-	od repair in 2 residents'				
	•	id 115.) (Refer to Tag 074				
		6(a)(1) Housekeeping &				
	Furnishings)	S(a)(1) Housekeeping &				
	i airiisiiiigs <i>j</i>					
	2. Based on interview	and observation the facility				
		in the residents room was in				

good repair. (Refer to Tag 076 10A NCAC 13F

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING			R
		HAL080003	B. WING			22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N C	ANNON BOULV	ARD		
	I	KANNAP	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 183	Continued From page	e 28	D 183			
	.0306(a)(3) Housekee	eping & Furnishings)				
	facility failed to assurclean and in good reprooms (#103, #202, #Tag 089 10A NCAC 1 Housekeeping & Furror 4. Based on observation failed to furnish one cresident in 10 of 19 m #107, #112, #120, #2 #211, and #212) and (rooms #103, #104, # #206, #207, #302). (F13F.0306(b)(5)(6)Hoto 5. Based on observation facility failed to assurof bed with a switch vin bed or a bedside later (rooms #102, #107, # #212) and 7 of 16 wo #104, #116, #119, #2 to Tag 093 10A NCAC Housekeeping & Furror 10 minus failed to assure facility failed to assure faci	tion and interview, the facility comfortable chair for each nen's rooms (rooms # 102, 04, #205, #208, #209, #210, 8 of 16 women's rooms #116, #119, #201, #202, Refer to Tag 091 10A NCAC pusekeeping & Furnishings) tions and interviews, the e there was a light overhead within reach of residents lying amp for 7 of 19 men's rooms #205, #208, #210, #211, and men's rooms (Rooms #103, 02, #206, and #207). (Refer C 13F .0306(b)(8) nishings)				
	facility failed to ensur conditioning units in r installed or protected residents for 3 reside	tions and interviews, the e built-in electric heating/air residents' rooms were so as to avoid hazards to nt's rooms (rooms #116, efer to Tag 107 10A NCAC r Requirements)				
	facility failed to assure B) successfully comp	vs and record reviews, the e 1 of 7 sampled staff (Staff leted an 80-hour Personal empetency Evaluation				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL080003	B. WING		R <b>12/22/2014</b>	
NAME OF PROVIDER OR SUPPLIER  KANNON CREEK ASSISTED LIVII	STREET ADD	PRESS, CITY, STA	ARD	12/22/2014	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
and Competency)  8. Based on observareviews, the facility for referral and follow-up with finger stick blood insulin, and schedule (Resident #2), and medication administres positive airway press to Tag 273 10A NCA  9. Based on observareview, the facility fadiets Mechanical Sof (Residents #15 and and (Refer to Tag 310 10 Nutrition and Food States of a medication order (Residents #1 and #1 Novolog sliding scale Prilosec. (Refer to Tag .1002(a) Medication  11. Based on observinterviews, the facility medications were added for sampled resider including pain medication godes of 2 sampled residents and 2 of 2 sampled residents for sliding scale orders for sliding scale	onths of hire. (Refer to Tag .0501 Personal Care Training .0501 Personal Care .05	D 183	DEFICIENCY)		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND I LAN O	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COWII ELTED
		HAL080003	B. WING		R 12/22/2014
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
KANNON (	CREEK ASSISTED LIVIN	G	NNON BOULV LIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
	reviews, the facility fathe Medication Admin of 8 residents (Residents (Refer to Tag 367 104 Medication Administra  13. Based on observate record reviews, the fareadily retrievable record reviews, the fareadily retrievable record reviews, the fareadily retrievable record reviews (Residents with orders for contronarcotic pain medicate medications. [Refer to .1008(a) (Type B Viol 14. Based on observate record reviews, the fareadily retrievable record reviews, the fareadily retrievable record reviews, the fareadily retrievable record reviews (Residents with orders for contronarcotic pain medicate medications. [Refer to .1008(a) (Type B Viol 15. Based on interviewable facility failed to assure screening for the pressubstances was perforstaff (Staff G) hired and employee began word Tag 992 G.S. & 131D Screening)	ations, interviews and record iled to assure accuracy of aistration Record (MAR) for 5 ents #1, #4, #6, #7, and #9). A NCAC 13F .1004(j) ation)  ations, interviews, and acility failed to assure a cord of controlled substances istration and disposition of aces for 7 of 8 sampled #1, #3, #4, #6, #7, and #9) ations, interviews, and acility failed to assure a cord of controlled substances including ions and narcotic anxiety ations, interviews, and acility failed to assure a cord of controlled substances instration and disposition of aces for 7 of 8 sampled #1, #3, #4, #6, #7, and #9) and alled substances including ions and narcotic anxiety at a cord of controlled substances including ions and narcotic anxiety at a cord of controlled substances including ions and narcotic anxiety at a cord and accord review, the controlled corned for 1 of 7 sampled for 1 of 7 s	D 183		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY
			A. BOILDING			Б
		HAL080003	B. WING			R / <b>22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULVA			
	I		OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 183	operations of the facility chain of circle personal care at aides, supervisors.  -The medication aide ARCCThe ARCC reports to Coordinator (RCC)The RCC reports to Interview on 12/22/14 Administrator revealershe was responsible the facilityShe was at the facilityShe was on-call 24 her.  Interview on 12/22/14 revealed: -The Administrator "rall the residents had a would either let the Arthe RCC knowIt depended on who staff they would talk to issuesThe residents would often because she was usually available for the The facility provided at the RCC know.	as responsible for the daily lity. command was as follows: ides report to the medication s, supervisors report to the the Resident Care the Administrator.  If at 3:10 pm with the ed: e for the daily operations of ty "just about every day". Indure a day if staff needed  If at 4:00 pm with 7 residents an" the facility. In any concerns or issues they dministrator, the ARCC or was available as to which o about any concerns or "go to" the ARCC more as the person that was	D 183			
	locked drawers have	ow for sufficient storage s to be placed in the				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					_	,
			B. WING		R	
		HAL080003	B. WING		12/2	2/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE. ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	IG	ANNON BOULV			
		KANNAP	OLIS, NC 28083	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG		130 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	VALL	]
				,		
D 183	Continued From page	e 32	D 183			
		ger be placed in the brown				
		room or in the black filing				
	cabinet in the RCC of					
		sured any discrepancies will				
	be immediately addre	essed with the Administrator				
	and pharmacist.					
	-The Administrator an	nd or ARCC will continue a				
	narcotic documentation	on and reconciliation audit				
	form to ensure compl	iance.				
	-The audit will be con	npleted for 10% of random				
		weeks, then weekly times 4				
	_	nonthly checks thereafter.				
		en to the executive Quality				
	Improvement (QI) cor					
		IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII				
	Management will ove	ersee and ensure as follows:				
	-The implementation					
		pre-employment drug				
	screening.					
		nployment to include CNAs				
	will have a pre-emplo					
		ng in documented in each				
	employee's file who re	equire the Personal care				
	Training class.					
	<ul> <li>-Medication orders ar</li> </ul>	nd accuracy of the				
	Medication administra	ation record are in place.				
	-The process for heal	thcare referral and				
	follow-ups.					
	-Physician orders for	ground foods are the correct				
	consistency.					
	-Dietary staff have be	een retrained and audit tools				
	are in place.					
	I	oors are in good repair.				
		ttered, heating and air				
	conditioning units are					
	_	oor condition, and a chair and				
		r each resident in their				
	-	Cach resident in their				
	rooms.					
	, -Management has im	plemented a monitoring			ļ	

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system for review and immediate follow-up for

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL080003	B. WING		12	R 2 <b>/22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	NG	CANNON BOULVAR	RD		
	T		POLIS, NC 28083			T
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 183	Continued From page	e 33	D 183			
	taken to the QI comm recommendations on CORRECTION DATE	ersight interventions will be nittee for review and further a monthly basis ongoing.				
D 273	10A NCAC 13F .0902	2(b) Health Care	D 273			
	` '	2 Health Care assure referral and follow-up nd acute health care needs				
	reviews, the facility fareferral and follow-up with finger stick blood insulin, and schedule (Resident #2), and 1	n, interviews and record ailed to assure health care of for 1 of 2 sampled residents d sugars and sliding scale ed fast acting insulin of 7 sampled residents for ation and CPAP (continuous				
	The findings are:					
	08/01/14 revealed: -Diagnoses included hypertension, hypogl - An order for Levemi analog) 70 units subd - An order for Novolo	diabetes, renal insufficiency, ycemia, and dyslipidemia. ir (Long acting insulin cutaneously 2 times a day. g (Rapid acting insulin utaneously 3 times a day with				

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	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					_	,
			B. WING		F	
		HAL080003	B. WING		12/2	2/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE. ZIP CODE		
			, ,	,		
KANNON	CREEK ASSISTED LIVIN	IG	ANNON BOULV			
		KANNAP	OLIS, NC 28083	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	RIAIE	DAIL
				,		
D 273	Continued From page	e 34	D 273			
		finger stick blood sugars) 3				
	times daily.					
	- An order for Novolog	g Insulin with sliding scale				
	insulin (SSI) three time	nes daily parameters as				
	follows:					
	FSBS 250-300 = 4 ur	nits,				
	FSBS 301-350 = 6 ur					
	FSBS 351-400 = 8 ur					
	FSBS 401-450 = 10 t	•				
	FSBS 451-500 = 12 t					
	FSBS 501-550 = 15 t					
	FSBS greater than 55	50 notify the physician.				
		101 0 1 1 0011				
	Review of Resident #					
	Medication Administra	ation Records (MARs)				
	revealed:					
	- Levemir scheduled	at 8:00 am and 6:00 pm				
	daily and documented	d as administered routinely				
	as ordered.					
	- FSBS testing was se	cheduled three times a day				
	at 7:00 am, 11:00 am	and 5:00 pm.				
	- FSBS values ranged	•				
	- No SSI required; no					
		cutaneously 3 times a day				
		and scheduled for 7:00 am.				
	11:00 am and 5:00 pr					
		5:00 pm was documented as				
	_	•				
		of the MAR (initials with a				
		derneath) from 10/16/14 to				
	10/25/14.	0 6 4047444				
		0 am from 10/17/14 to				
	10/25/14 ranged 125					
		mentation the physician was				
		og evening doses being				
	refused from 10/16/14	4 to 10/25/14.				
	Review of Resident #	2's November 2014 MAR				
	revealed:					
		cutaneously 3 times a day				

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with meals was listed and scheduled for 7:00 am,

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _			
		HAL080003	B. WING		12/2	? 2/2014
NAME OF D			DRESS, CITY, STA	TE ZID CODE	1 12/2	2/2014
NAME OF P	ROVIDER OR SUPPLIER		ANNON BOULV	,		
KANNON	CREEK ASSISTED LIVIN	IG	DLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 35	D 273			
	11:00 am and 5:00 prints at 5 refused on the front of circle and refused un 11/24, and 11/25.  FSBS values at 7:00 11/26/14 ranged 170  There was no documotified for the Novolorefused on 11/20, 11/20 am and 5:00 prints at 5 refused on the front of circle and refused un 12/04, 12/08-12/11, 1	m. 6:00 pm was documented as of the MAR (initials with a derneath) on 11/20, 11/23, 0 am from 11/21/14 to to 245. mentation the physician was og evening doses being 23, 11/24, and 11/25. 62's December 2014 MAR focutaneously 3 times a day and scheduled for 7:00 am, m. 6:00 pm was documented as of the MAR (initials with a derneath) on 12/01, 12/03, 12/13, 12/16 and 12/17. 0 am from 12/09/14 to 159 to 252. mentation the physician was og evening doses being 2014. 62's record revealed a value on 12/06/14 of 7.0. t is a standard tool to ar control in residents known				
	revealed: - Medication Aides (N	at 4:25 pm with the are Coordinator (ARCC)  (AA) were responsible to 'MARs for incomplete				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
,	o. 001.11.2011011		A. BUILDING:	A. BUILDING:		
		HAL080003	B. WING		12	R 2/ <b>22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		1808 N C	ANNON BOULVAR	RD		
KANNON	CREEK ASSISTED LIVIN	NG .	OLIS, NC 28083			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLETE DATE
				DEFICIEN	CY)	
D 273	Continued From page	e 36	D 273			
	decumentation (heles	a left undecumented)				
	documentation (holes	nould notify the physician				
	when residents refus					
		dents' records physician				
	contacts.	de vendens else des feu				
		do random checks for				
		tation on the MARs but have				
	prescriber for refusals	monitor for notifying the				
	prescriber for refusals	5.				
	Interview on 12/22/14	4 at 9:00 am with a day shift				
	medication aide reve	<del>-</del>				
		edication Administration				
		ermine how much insulin to				
	administer to a reside					
	- She looked at the re	esidents' MARs every day for				
	changes to the sliding					
		nt does not want the full				
	amount of insulin acc	cording to the sliding scale				
	order "I give them wh					
	- She said if a resider	nt can tell me how they feel				
	and they are not conf	fused, "I listen to them."				
	- She documented th	e amount of insulin she				
	actually administered	I to the resident on the				
	resident MAR.					
		ent on the back of MAR or in				
	nurse progress notes					
		ulin outside the parameters				
	as ordered by the phy					
		did not notify the physician				
		refuses insulin or when she				
		rtial amounts of insulin per				
	the resident request.					
	Telephone interview	on 12/22/14 at 10:15 am with				
	the facility Nurse Pra					
		on that the facility would				
	-	ing scale parameters as				
		cian or contact the office if				
		ot compliant with the order.				

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STATE FORM 6899 O3GX11 If continuation sheet 37 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:	
		HAL080003	B. WING		R 12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
KANNON CREEK ASSISTED LIVING		IG .	NNON BOULV		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	
D 273	Continued From page	e 37	D 273		
	-She could not recall the office with FSBS of particular residents, in				
	the facility Registered staff was to notify the resident requested a	on 12/22/14 at 12:40 pm with I Nurse revealed the facility physician every time a partial amount of insulin to fused insulin as ordered by			
	with the Adminstrator -She was aware seve scale insulin with para physicianShe was not aware N administering partial or residents per the resi -She said the facility p orders the physician I -She assumed the M physician orders for th parameters and admi of insulin that was ord - MAs should notify a refusals of insulin.	eral residents were on sliding ameters as ordered by the Medication Aides (MA) were dosage of insulin to the dent request. policy was to follow the had written. As were following the he sliding scale insulin inistering the correct amount dered to the residents. resident's physican for all			
	scale insulin with para -She said the facility para partial dose of in give it, they were to dand call the physician	inator revealed: eral residents were on sliding ameters. policy was, if a resident ask asulin the MAs were not to locument refused on MAR			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILBING.		R
		HAL080003	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		1808 N CA	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	IG KANNAPO	DLIS, NC 28083	l .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 38	D 273		
	the resident request vershe said the facility ladministration of insular Interview on 12/22/14 shift medication aide - Residents sometime including insulin She routinely document to document on the bear of the MAR (circle initiated to document on the bear of the said in a row; she refusal Staff were supposed contacts in the reside	vithout an order. had an inservice for the lin a few weeks ago. hat 3:00 pm with a evening revealed: he refused medications hented refusals on the front hials) and tried to remember hack of the MAR. he call physician after 3 hight not call for one SSI			
	#2 revealed: - He had been a diab - He was aware he winsulin, one long actir - He received insulin sliding scale He sometimes refusinsulin if his blood sugless) because he was would drop too low if evening meal He was not aware if practitioner was awar  B. Review of Resider 10/07/14 revealed: - Diagnoses included obstructive pulmonary	etic for a long time. as receiving 2 types of ag and one short acting. both scheduled and on a  ed the evening meal time gar was low (around 120 or a concerned his blood sugar he did not eat much of the  his physician or nurse e of his refusals.  at #1's current FL2 dated			

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dysphagia, diabetes.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_
		HAL080003	B. WING		R <b>12/22/2014</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON CREEK ASSISTED LIVING		IG .	NNON BOULV LIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 273	Continued From page	= 39	D 273		
	-Medication orders an	nd treatment on the current ous positive air pressure			
	Review of the Reside Resident #1 was adm	ent Register revealed nitted to the facility 10/25/13.			
	Review of Resident # December 2014 Medi Records (MARs) reve -CPAP was not listed	ealed:			
	-The Registered Nurs documented the resid use while sleeping. -The RN comments a -The resident express ordered and wear the -The RN noted that m needed a new nasal p	ew dated 08/16/14 revealed: se (RN) preparing the review dent had a CPAP machine to and recommendations were: sed he was trying to do as e CPAP. hachine was clean but			
	revealed: -The resident had a C sleeping.	review dated 11/22/14 CPAP machine to use while ean, but still needed a new sived one."			
	#1's CPAP machine re- It was sitting on a be- The hose was attach broken. The machine was ab	n/14 at 11:10 am of Resident revealed: redside table next to the bed. ned, but the nasal piece was note to power on, but without flowed to the resident's			

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Division of	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL080003	B. WING		12/22/2014
		HALU60003			12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		1808 N CA	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	IG KANNAPO	DLIS, NC 28083	3	
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
D 273	Continued From page	2 40	D 273		
	Continued From page	3 10			
		ation on 12/19/14 at 11:12			
	am with Resident #1				
	•	e facility he did a sleep			
	study.				
		said he had sleep apnea and			
	ordered the CPAP.				
		to use the machine since			
	April 2014.				
	-The machine needed	d a new nasal piece.			
	-Without the nasal pie	ece air did not flow through			
	the mask to his face.				
	-The nurse that visits	the facility was aware.			
	-He also told the prev	rious RCC and current RCC			
	that he needed a new	v nasal piece.			
	-The resident was obs	served falling asleep during			
	conversation and loud	dly snoring.			
		at 11:22 am with Resident			
	#1's family member re	evealed:			
		time, all he does is sleep."			
	-The family said wher	n the resident was awake he			
	was alert, but the min	ute he sat down he fell			
	asleep.				
	-The resident had CO	PD and sleep apnea.			
	-He needed the CPAF				
	-The CPAP had not w	orked in seven or eight			
	months.				
		t comes to the facility was			
	aware of the broken r				
		old facility staff, but nothing			
	has been done.				
		at 11:45 am and 3:04 pm			
	with the LHPS nurse				
		IPS reviews in May 2014			
		us RCC aware the nasal			
	piece needed to be re				
	-She also documente	d the need for the repair on			

the LHPS reviews.

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Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLE	TED
			-	A. BUILDING:		
			5 14/110		R	
		HAL080003	B. WING		12/2	2/2014
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZID CODE		
TWANE OF T	TOVIDER OR OUT FILE		, ,	,		
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULV			
KANNAP		OLIS, NC 28083	3			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	MAIE	DATE
D 273	Continued From page	e 41	D 273			
		again made staff aware the				
	· · · · · · · · · · · · · · · · · · ·	o be repaired and she				
	documented on her re	•				
		S review on 11/22/14, she				
		e was still not working.				
	-She documented on	•				
		ell phone to take pictures of				
	the machine to find th	ne supplier to repair the				
	machine.					
	-It was the facility's re	esponsibility to contact the				
	supplier to get the ma	achine fixed.				
	-She recalled verbally	telling the previous RCC a				
	couple of times Resid	lent #1's CPAP needed to be				
	repaired.					
	•	re was a problem with the				
	resident's physician.	·				
		ed the facility after 5:00 pm				
	and on weekend.	, , , , , , , , , , , , , , , , , , ,				
		and leaving a note for				
		cause it was after hours.				
	managoment etan se					
	Interview on 12/19/14	at 11:30 am with the sleep				
	center revealed:	at the am mar are eresp				
		Resident #1 needed a new				
	nasal piece for his CF					
		wo years since they had				
	seen Resident #1.	wo years since they had				
		to get the part for Resident				
	#1's machine, but the					
	considered a new pat					
	considered a new par	uent.				
	Interview on 12/10/14	at 12:00 pm and 2:20 pm				
		re Director (RCC) revealed:				
	-She does not recall s	, ,				
		the LHPS nurse stating				
	•					
		needed a nasal piece.				
	-She did not review L	HPS reviews to see				
	recommendations.	and developed LUDO				
		reviewed LHPS reviews;				
	they were filed in the	resident's record.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING	B. WING  ESS, CITY, STATE, ZIP CODE		,
		HAL080003	B. WING		12/2	2/2014
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N C	ANNON BOULV	ARD		
TOTALLO	ONLEN AGGIOTED EIVIN	KANNAP	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 42	D 273			
	-She was unaware the #1's CPAP needed to The RCC before here the RCC working on its -She was unaware the to get the nasal pieces. She was unable to rest that he needed a new machineShe was sure no core #1's physician regards she did not know about -She stated, also the with the CPAP and the the resident had the resident with the resident with the resident #1's physician regards he did not know about -She stated, also the with the CPAP and the resident had the resident with the resident had the resident #1's physician regards which will be resident with the resident had so important the nasal president sleep better 10A NCAC 13F .0904 Service 10A NCAC 13F .0904 (e) Therapeutic Diets (d) All therapeutic dieters.	e nasal piece on Resident be replaced. was aware and she recalled it. e steps the RCC had taken e replaced. ecall Resident #1 telling her in nasal piece for this CPAP  Intact had been with Resident ing the nasal piece because out the nasal piece. resident came to the facility e physician was unaware machine.  If at 3:45 pm with the nurse sician's office revealed: the resident had a CPAP  If them the machine needed deep apnea it was very fiece be replaced to help the and function during the day.  In the sident had a CPAP  If the side	D 310			
	supplements and thic served as ordered by This Rule is not met	kened liquids, shall be the resident's physician.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL080003	B. WING	B. WING 12	
		HALU000003			12/22/2014
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET AI		DRESS, CITY, STA		
KANNON	CREEK ASSISTED LIVIN	IG .	NNON BOULV		
			LIS, NC 28083		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 310	Continued From page	e 43	D 310		
	review, the facility failed to assure the therapeutic diets Mechanical Soft (MS) for 2 of 2 residents (Residents #15 and #16) were served as ordered.				
	The findings are:				
	05/01/14 revealed: -Diagnoses included schizoaffective disord hypertension, left extroof hearingAn order for regular revealed Resident #1 diet.  Review of the facility revealed: -A MS menu was avaservice staffA ground diet was the The lunch on 12/17/1 MS diet was to consist bun, battered corn nutries.	t posted in the kitchen 5 was to be served a MS  therapeutic diet menus  iilable for use by the food  e same as a MS diet.  14 for residents ordered a st of grounded hot dog on a luggets, baked beans, spiced			
	dog on a bun topped slaw, cupcake with ic -The resident was serent resident was sleminutesTwo staff tried to aro -The resident woke u	nch meal served on revealed: erved whole extra-long hot with chili, baked bean, cole ing, and milk. ated at the "feeding table." eep at the table for 20 use the resident. p. ide (PCA) at the table used a			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		1141 000003	B. WING		R
		HAL080003			12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
	·	1808 N C/	ANNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	IG KANNAP	OLIS, NC 28083	3	
(X4) ID	SUMMARY ST.	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	(EACH DEFICIENC)	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE
	<u> </u>			DEI IOIERO I /	
D 310	Continued From page	e 44	D 310		
	-The resident ate the	meal without assistance.			
	-The resident consum	ned 100% of the meal.			
	Interview on 12/14/14 revealed:	4 at 12:45 pm with the PCA			
	-Resident #15 was at	ole to feed himself.			
		resident was ordered a MS			
	diet.				
	-When a resident is o	ordered MS diet the meat			
	was always cut-up at				
		15 was unable to respond			
	verbally.				
	Based record review,	, observation and attempt			
	interview on 12/17/14	and 12/18/14, it was			
	determined that Resid	dent #15 was not			
	interviewable.				
	Refer to interview on	12/17/14 at 12:50 pm with			
	the Food Service Mar				
	Pefer to interview on	12/17/14 at 1:00 pm with the			
	Cook.	12/11/14 at 1.00 pm with the			
	COOK.				
	B. Review of Residen	nt #16's current FL2 dated			
		mental retardation, seizure,			
	_	/, edema, anemia, and			
	hypothyroidism.	, odoma, anoma, a			
	-An order for regular	ground (MS) diet.			
	- 	, ,			
		t posted in the kitchen			
	revealed Resident #16 was to be served MS diet.				
	· ·	therapeutic diet menus			
	revealed:	silable for use by the food			
	service staff.	ailable for use by the food			
		ne same as a MS diet.			
		14 for residents ordered a			

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CONNECTION	IDENTIFICATION NOWBER.			(X3) DATE SURVEY COMPLETED	
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. E			COMPLETED	
	HAL080003	B. WING	B. WING		
OVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	12/22/2014	
	1808 N CA	, ,	•		
REEK ASSISTED LIVIN	G				
SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
Continued From page	÷ 45	D 310			
MS diet was to consist of ground hot dog on a bun, battered corn nuggets, baked beans, spiced pears, milk and beverage of choice.					
12/17/14 at 11:30 am Resident #16 was se dog on a bun topped nto 10 pieces, baked with icing, and milk. The resident was abl	revealed: verved whole extra-long hot with chili that was cut-up bean, cole slaw, cupcake e to feed himself.				
nterview on 12/17/14	and 12/18/14, it was				
Refer to interview on Cook.	12/17/14 at 1:00 pm with the				
Service Manager reverse. The facility had two aground.  The did not realize the beground.  He had always under chopped meats.  He did not realize the meats should be ground.  He will check to ensudiet orders.  He had always instru	ealed: altered diets, chopped and nat MS diet required meats rstood MS diet to be at Residents #15 and #16 inded. are that he had the current acted staff that meats for				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page MS diet was to consiste our, battered corn nurbears, milk and bever Deservation of the lurity 12/17/14 at 11:30 am Resident #16 was seed on a bun topped on the 10 pieces, baked with icing, and milk. The resident was able to 10 pieces, baked with icing, and milk. The resident consum Based on record reviet on terview on 12/17/14 determined that Residenterview on 12/17/14 determined that Residenterviewable.  Refer to interview on the Food Service Marager reveals and the facility had two appround. The did not realize the obe ground. The had always under the had always instructed the orders. He had always instructed the orders. He had always instructed the orders ordered MS	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 45  MS diet was to consist of ground hot dog on a boun, battered corn nuggets, baked beans, spiced opears, milk and beverage of choice.  Observation of the lunch meal served on 12/17/14 at 11:30 am revealed: Resident #16 was served whole extra-long hot dog on a bun topped with chili that was cut-up into 10 pieces, baked bean, cole slaw, cupcake with icing, and milk. The resident was able to feed himself. The resident consumed 100% of the meal.  Based on record review, observation and attempt interview on 12/17/14 and 12/18/14, it was determined that Resident #16 was not interviewable.  Refer to interview on 12/17/14 at 12:50 pm with the Food Service Manager.  Refer to interview on 12/17/14 at 1:00 pm with the Cook.  The facility had two altered diets, chopped and ground. The did not realize that MS diet required meats to be ground. He had always understood MS diet to be chopped meats. He did not realize that Residents #15 and #16 meats should be grounded. He will check to ensure that he had the current	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  OCCURRENCE AND A STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Description of Light of the L	REEK ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREPER IX TAG  D 310  PROVIDERS PLAN OF CORRECTION PREETIX TAG  CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  SUMMARY STATEMENT OF DEFICIENCIES  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  SUMMARY STATEMENT OF LIVING INFORMATION)  D 310  D 310  STATEMENT OF LIVING INFORMATION  TAG  D 310  D 310	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		R <b>12/22/2014</b>
KANNON CREEK ASSISTED LIVING 1808 N CA		DRESS, CITY, STA NNON BOULVA DLIS, NC 28083	ARD	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 310	revealed: -She did not grind the grinding them smashe was "smashey." -She chopped the me MS dietChopped meat was o	ff serving the meal.  at 1:00 pm with the Cook  thot dogs today because ed the meat and made it  at for all residents ordered cut-up into bite sized pieces. and the meat for residents  me menu for MS diet	D 310		
D 344	the resident's physicia for verification or clari medications and treat (1) if orders for admission or readmission are not the san The facility shall ensuclarification is documer record.  This Rule is not met Based on observation interview, the facility the sand the	Medication Orders ne shall ensure contact with an or prescribing practitioner fication of orders for tments: sion or readmission of the d and signed within 24 hours nission to the facility; ear or complete; or on forms are received upon sion and orders on the ne. ure that this verification or ented in the resident's	D 344		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		R <b>12/22/2</b>	014
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	12/22/2	014
KANNON	CREEK ASSISTED LIVIN	1808 N CA	ANNON BOULV	ARD		
		KANNAPO	DLIS, NC 28083	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF T	BE C	(X5) COMPLETE DATE
D 344	Continued From page	e 47	D 344			
	sliding scale, Vistaril,	and Trazodone.				
	The findings are:					
	The findings are:  Review of Resident #7's current FL2 dated 05/01/14 revealed: -Diagnoses of diabetes, anemia, hypothyroidism, chronic obstructive pulmonary disease, renal insufficiency, asthma, and edema.  1. Diabetic medications ordered on the current FL2 included: -Humalog (A fasting acting insulin that is used to lower blood glucose level) sliding scale four times daily with parameters of: 62-150= 0 units; 151-200= 2 units; 201-250= 4 units; 251-300= 6 units; 301-350= 8 units; 351-400= 10 units; greater than 400 call the physicianHumalog 10 units twice daily before lunch and supperLantus (long acting insulin to lower blood glucose level) 35 units in morning and at bedtime.					
	10/25/14.  -The resident was hose complications.  -Discharge medicationshovelog (Fast acting sugar) subcutaneous times daily before medicationshovelog 10 units twick and Supper).	summary report dated spitalized for respiratory ns included: i insulin to lower blood ly with sliding scale three hals (greater than 150 = 2				
		sident #7's record revealed: tion administration records				

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(MARs) signed by the physician (physician order

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DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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			B. WING		R
		HAL080003	B. Wto		12/22/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		1808 N CA	NNON BOULV	ARD.	
KANNON	CREEK ASSISTED LIVIN	G	LIS, NC 28083		
			10, 110 2000		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD)	( - /
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
5.044			5.044		
D 344	Continued From page	e 48	D 344		
	sheets/POS) on 11/18	8/14.			
	•	le four times daily with			
	•	0 units; 151-200= 2 units;			
	-	1-300= 6 units; 351-400= 10			
	units; greater than 40				
		covered for blood sugars			
	301-350.	sovered for stood edgate			
		ice daily before meals (lunch			
	and supper).	(			
		orning and at bedtime.			
		g			
	Review of Resident #	7's October 2014 Blood			
	Glucose Record reve				
	-Finger Stick Blood S	ugars (FSBS) testing was			
		a day at 7:00 am, 11:00 am,			
	5:00 pm, and 9:00 pm	-			
		nented as administered for			
	•	liding scale parameters on			
	5/1/14 FL2.	maning scale parameters on			
		as documented administered			
	twice daily at 11:00 a				
		documented twice daily at			
	10:00 am and 10:00 p				
	-FSBS's range from 6				
	Review of Resident #	7's November 2014 Blood			
	Glucose Record reve				
	-FSBS testing was so	heduled four times a day at			
	7:00 am, 11:00 am, 5				
		nented as administered for			
		liding scale parameters on			
	5/1/14 FL2.	9 p			
	-Humalog 10 units wa	as documented as			
		aily at 11:00 am and 5:00			
	pm.	, ,			
	-Lantus 35 units was	documented as			
		aily at 10:00 am and 10:00			
	pm.	, , , , , , , , , , , , , , , , , , , ,			
	-FSBS's range from 8	89 to 420.			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		. ,	(X3) DATE SURVEY COMPLETED	
			_			R	
		HAL080003	B. WING		12	/22/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV				
		KANNAPO	DLIS, NC 28083				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
D 344	344 Continued From page 49		D 344				
D 344	Review of Resident # Glucose Record rever-FSBS testing was so 7:00 am, 11:00 am, 5 -Humalog was documblood sugars within st 5/1/14 FL2Humalog 10 units was administered twice dapmLantus 35 units was administered twice dapmFSBS's range from 9  Observation on 12/19 #7's medications on h -The printed pharmac sliding scale four time 62-150= 0 units; 151- units; 251-300= 6 unit 351-400= 10 units; gr physician, and Humal before lunch and supp -The dosage per phar Lantus was 35 units in at bedtime, filled 12/0  Review of Resident # -No documentation of of any type with Resid the medications Humal -No clarification of the times vs. three times -No clarification of the	7's December 2014 Blood aled: heduled four times a day at ::00 pm, and 9:00 pm. hented as administered for iding scale parameters on as documented as sily at 11:00 am and 5:00 documented as sily at 10:00 am and 10:00 do to 318.  1/14 at 4:30 pm of Resident and at the facility revealed: by label on the Humalog was sed ally with parameters: 200= 2 units; 201-250= 4 ts; 301-350= 8 units; eater than 400 call the log 10 units twice daily oper. The macy printed label for an the morning and 37 units 8/14.  7's record revealed: for contact or communication dent #7's physician to clarify alog vs. Novolog. e sliding scale parameters. e Lantus 35 units twice daily	D 344				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLI	
					 	<b>.</b>
		HAL080003	B. WING		1	2/2014
			_ <b>.</b>		1 12/2	2/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULV			
			OLIS, NC 28083			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 344	Continued From page	e 50	D 344			
	dispensing pharmacy	staff used to fill Resident				
	#7's medications reve					
	-	of the hospital discharge				
	summary report date					
	-The orders should have	to the physician to clarify any				
	medications changes					
	•	ensed Novolog for Resident				
	#7.					
	-There was not a hug	e difference in Humalog vs.				
	Novolog, however if he physician ordered					
	Novolog, then that was what should be					
	administered to the re					
	dated 10/17/14.	d a refill request for Lantus				
	morning and 37 units					
	<ul> <li>-He was unaware wh the bedtime Lantus d</li> </ul>	y the physician increased osage.				
	<ul> <li>Orders sent to the pl facility.</li> </ul>	harmacy are not sent to the				
	_	esponsibility to communicate				
		obtain and/or clarify orders.				
		that when the physician				
		e facility was also notified by				
	the physician.  No one at the facility	had called them to clarify				
	the Humalog or Lantu					
	and manning or manning					
	Interview on 12/19/14	at 4:40 pm with Staff D				
	(Medication Aide) on	•				
		ed Resident #7's physician				
	to clarify the medicati					
	discharge summary r	eport. in October Resident #7 was				
		piratory complications.				
	-	eturned to the facility she				
	was not on duty.	taniba to the lability one				
	-The medication aide	on duty should have				

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compared the medications on the discharge

STATE FORM 6899 O3GX11 If continuation sheet 51 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL080003	B. WING		R 12/2	2/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	-	
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV			
	Г	KANNAPO	LIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 344	Continued From page 51		D 344			
	have been made with clarify the orders.  -The person coming of check behind that me orders were missed.  -She was unaware he Resident #7's hospital not clarified with the reshe had not realized had changed.  -Staff doing the week picked up the medical the MAR.  -She was sure Reside been contacted regard because the change of the MARs.  -Also, there should be resident's record.  -If it was not document.	e identified contact should the resident's physician to on the next shift was to dication aide to ensure no ow or why medications on Il discharge summary were esident's physician. Resident #7's Lantus order ly cart audits should have tion label was different from ent #7 physician had not ding the change in Lantus, would be documented on e some documentation in the inted it was not clarified.				
	#7's physician reveale	at 10:15 am with Resident ed:  ot seen the resident in				
	-She was aware the r hospitalized, but was order changes. -No one at the facility sliding scale orders. -The physician did ch was in October 2014 hospitalization. -There were no notes Lantus dosage had be	not aware of medication  called to clarify Humalog or ange the Lantus but that before the resident's  specific to why the bedtime een increased.				
	have been contacted	m, the physician should before now.				

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-No one at the facility called to clarify Resident

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
7.1.12 1 27.1.1	5. GG.W.EG.WG.	is a transfer to the state of t	A. BUILDING: _				
		HAL080003	B. WING		l l	R / <b>22/2014</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
KANNON	CREEK ASSISTED LIVIN	IG .	NNON BOULV DLIS, NC 28083				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 344	Continued From page 52		D 344				
	#7's Lantus order.  Based on record review, observation and attempt interview on 12/19/14 and 12/22/14 it was determined that Resident #7 was not interviewable.						
	05/01/14 revealed:	nt #7's current FL2 dated ncluded Vistaril (used to treat mes daily.					
	Review of Resident #7's record revealed: -A hospital discharge summary report dated 10/25/14Medication orders included Vistaril 50mg four times daily.						
	(MARs) signed by the sheets) on 11/18/14 r	ation administration records e physician (physician order					
	December 2014 MAR four times daily was s pm, 5:00 pm and 10:0 -Staff documented the	e administration of Vistaril r from November 1, 2014					
	#7's medications on h -The dosage per phare Vistaril was 50mg one neededThe medication was						
	Interview on 12/22/14	at 9:20 am with the					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		_	
		HAL080003	B. WING		R <b>12/22/2014</b>	
			1		12/22/2014	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
KANNON	CREEK ASSISTED LIVIN	IG	NNON BOULV LIS, NC 28083			
	OUR MARK OT		1			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 344	Continued From page 53		D 344			
D 344	dispensing pharmacy #7's medications reve -They had an order of 50mg every 8 hours a -The prescription labe current order accordir -On 10/21/14 they dis -Facility staff should r medication three time required PRN docum resident needed the r -Facility staff should r the physician to ensu medication order.  Interview on 12/19/14 (Medication Aide) rev -She was unaware th Vistaril medication wa printed on the MARIt was the facility's po discrepancy the pharm contacted to clarify th -She had not contacte to clarify the orderAn audit of the medic and someone should discrepancy and clari  Interview on 12/22/14 #7's physician revealed	r staff used to fill Resident ealed: ated 10/20/14 for Vistaril as needed. el on the medication was the ing to their record. spensed 180 tablets. not have administered the est daily without doing the entation to show why the medication. have clarified the order with re it was the current  If at 4:48 pm with Staff D, ealed: e prescription label on as different from the order colicy if there was a macy or physician should be de order. ed Resident #7's physician cation cart was done weekly have picked up that fied the order.  If at 10:12 am with Resident	D 344			
	several monthsDuring the visit no or there was a discrepal of VistarilNo one at the facility	ne at the facility informed ncy with the administration called to clarify the order. rent from the prescription				

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physician to clarify the order.

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
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			D WING		F	
		HAL080003	B. WING		12/2	2/2014
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			NNON BOULV	,		
KANNON	CREEK ASSISTED LIVIN	G				
		KANNAPO	DLIS, NC 28083	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
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				·		
D 344	Continued From page	e 54	D 344			
	Vistoril should have b	and administrated as 50mm				
		peen administered as 50mg				
	every 8 hours as need	dea.				
	0 M P P					
		on the current FL2 dated				
		zodone (used to treat				
	schizophrenia) 100mg					
	Review of Resident #					
		summary report dated				
	10/25/14.					
	_	n orders include Trazodone				
	100mg at bedtime.					
	Review of Resident #	7's November 2014 and				
	December 2014 MAR	ls revealed:				
	-Trazodone 100mg w	as documented as				
	administered daily at	8:00 pm.				
	-Staff documented the	e administration of				
	Trazodone 100mg da	ily from November 1, 2014				
	through December 21	-				
		,				
	Observation on 12/19	/14 at 4:30 pm of Resident				
		and at the facility revealed:				
		macy printed label for				
	Trazodone was 150m					
	-The medication was	-				
	The medication was					
	Interview on 12/22/14	at 9:20 am with the				
		staff used to fill Resident				
	#7's medications reve					
		3/14 for Trazodone 150mg at				
	bedtime.	or 14 for mazodone roung at				
		they did not have a copy of				
	• • •	they did not have a copy of				
		sheet dated 11/18/14 or the				
	FL2 dated 05/01/14.	andianana diference (CC				
		as dispensed for a quantity				
	•	ember, and December				
	2014.					
		ıld have called to find out				
	why the prescription I	ahal was different from the	1			

MAR.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
, and i Laive	CONTROLLON	SEATH OF WORLDER.	A. BUILDING: _			
		HAL080003	B. WING		R <b>12/22/2014</b>	
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
KANDON		1808 N CA	NNON BOULV			
KANNON	CREEK ASSISTED LIVIN	G KANNAPO	LIS, NC 28083	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	Ξ
D 344	Continued From page	e 55	D 344			
	-As of today's date no called to clarify the me	one at the facility had edication order.				
	#7's physician reveale	at 10:12 am with Resident ed: ot seen the resident in				
	several months.	change the Trazodone				
	bedtime.	ge should be 150mg at				
		last visit, no one at the was a discrepancy with				
	(Medication Aide) on	•				
	<ul><li>-She was unaware the changed.</li><li>-The medication aide</li></ul>	e order for Trazodone had administering the				
	medication should real before administering to	ad the prescription label the medication.				
	clarify the Trazodone	I have been contacted to order. mentation the order was				
	clarified, then the phy contacted.					
	Based on record revie interview on 12/19/14 determined that Resid interviewable.	•				
D 358	10A NCAC 13F .1004 Administration	e(a) Medication	D 358			
		Medication Administration ne shall assure that the				

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preparation and administration of medications,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R	
	HAL080003	B. WING		12/22/2014	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
KANNON CREEK ASSISTED LIVIN	1808 N CA	NNON BOULVA	ARD		
RANNON CREEK ASSISTED EIVIN	KANNAPO	DLIS, NC 28083	3	<u>,                                      </u>	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
by staff are in accorda (1) orders by a licens which are maintained (2) rules in this Section and procedures.  This Rule is not metal TYPE B VIOLATION  Based on observation interviews, the facility medications were addressed of 7 sampled resident including pain medicate reflux, anti-psychotic, and 2 of 2 sampled resorders for sliding scal #7).  The findings are:  Tour during initial entrestrete with resident complained about the out of their medicationThe medications were health conditionsThe residents said stem why the medication were residents said the because staff did not pill was givenThe residents were contacted.	prescription, and treatments ance with: and prescribing practitioner in the resident's record; and on and the facility's policies  as evidenced by:  as evidenced by:  as evidenced by:  as evidenced by:  as evidenced for 2 s (Residents #7 and #8), and antifungal medications, asidents with physician e insulin (Resident #2 and  ance to the facility revealed: ents revealed they facility being continuously as. e used to treat various  aff did not tell them how or as out. ey were sure it was request a refill until the last	D 358			
meds, or acid reflux p	ortant like pain pills, anxiety ills that were out up to one t #7's current FL2 dated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	SURVEY	
			A. BOILDING.			_
		HAL080003	B. WING		12	R / <b>22/2014</b>
			<b>!</b>		1 12	122,2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
KANNON	CREEK ASSISTED LIVIN	IG .	CANNON BOULVAR	lD .		
			POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 57	D 358			
		es, anemia, hypothyroidism, ulmonary disease, renal , and edema.				
	1. Medication orders	did not include Prilosec.				
	Review of Resident # -Hospital discharge s 10/25/14Discharge medicatio daily.					
	-A copy of hand written medication administration records (MARs) (physician order sheets) signed by the physician on 11/18/14Orders included Prilosec 20mg once daily.					
	December 2014 MAF was scheduled at 6:0 -Staff documented the	7's November 2014 and Rs revealed Prilosec 20 mg 0 am. e administration of Prilosec ember 1, 2014 through				
	#7's medications on h	n/14 at 4:30 pm of Resident nand at the facility revealed lable for administration.				
	responsible for admir -Prilosec was not on -She was unaware ho been out. -The medication was and usually administe	atty revealed: shift. ation aide would have been aistering the Prilosec. the medication cart. ow long the medication had scheduled before breakfast ered at 6:00 am. searched for a refill request				

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DIVISION	n Health Service Regu	iation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (		(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		R
		HAL080003	D. WING		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	
	10115211 011 001 1 21211				
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULV		
		KANNAPO	DLIS, NC 28083	3	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MATE
			+	,	
D 358	Continued From page	e 58	D 358		
	1 0				
	Interview on 12/22/14				
		staff used to fill Resident			
	#7's medications reve				
	_	daily was dispensed for			
	quantity of 30 on 10/1				
	-The medication was	not on automatic refill and			
	the facility had to requ	uest the medication be			
	re-filled.				
	-Based on the dispen	sing history of the			
	medication, the medic	cation would have run out			
	between December 1	0-13, 2014.			
	-As of today, Decemb	per 22, 2014 the facility had			
	•	a refill of the medication.			
	Interview on 12/22/14	at 9:43 am with the			
	Resident Care Coord				
		not have run out of the			
	Prilosec.	iot navo ran out or the			
		icy when medications were 5			
		ation Aide on the cart was to			
	reorder the medicatio				
		rere done by Medication			
	•	cations did not run out.			
		at residents complained			
		ning out of medication.			
	about continually funi	ning out of medication.			
	Dood on record reside	our observation and attempt			
	interview on 12/17/14	ew, observation and attempt			
	determined that Resid	uent#/ was not			
	interviewable.				
	O Davison for P. C.	:			
		ions ordered on the 05/01/14			
		10mg was ordered twice			
	daily.				
		discharge summary report			
		led discharge medications			
	included: Prolixin 10m	ng twice daily was ordered.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL080003	B. WING		12	R 2/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STATE	E, ZIP CODE		
		1808 N C	ANNON BOULVAR	RD		
KANNON	CREEK ASSISTED LIVIN	G	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	D 358 Continued From page 59		D 358			
	Review of a copy of hadministration record sheets) signed by the	nand written medication s (MARs) (physician order physician on 11/18/14 ded Prolixin 10mg twice				
	December 2014 MAF twice daily was sched pm.	7's November 2014 and Rs revealed Prolixin 10mg duled at 10:00 am and 10:00				
	-Staff documented the administration of Prolixin 10mg twice daily from November 1, 2014 through December 22, 2014.					
	#7's medications on h	1/14 at 4:30 pm of Resident nand at the facility revealed able for administration.				
		uty revealed:				
	medication.	e day shift administered the				
		olicy to request a refill of tablets left.				
	#7's medications reversely and twice of the control	staff used to fill Resident ealed: daily was dispensed for l3/14 and 11/10/14. not on automatic refill and uest the medication be				

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STATE FORM 6899 O3GX11 If continuation sheet 60 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
				_	
		HAL080003	B. WING		R <b>12/22/2014</b>
				TE 710 0005	1 12/22/2011
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,	
KANNON	CREEK ASSISTED LIVIN	IG .	NNON BOULV		
	T		DLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 60	D 358		
	medication it would have cawas down to no less table. Also, the weekly card Aides should have ide the medication.	ave run out around 14. ber 22, 2014 the facility had of the medication.  If at 9:43 am with the inator revealed: not have run out of the Illed when the medication than 3-4 pills. It audits by the Medication entified it was time to reorder of caught during the cart Aide administering the			
	interview on 12/17/14 determined that Residinterviewable.  3. Review of medicati FL2 revealed Cogent Review of hospital dis dated 10/25/14 reveal bedtime was ordered Review of a copy of hadministration record.	dent #7 was not  ion ordered on the 05/01/14 in 1mg daily was ordered. scharge summary report led Cogentin 1 mg at  and written medication s (MARs) (physician order e physician on 11/18/14			
		7's November 2014 and Rs revealed Cogentin 1mg			

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was documented daily at 8:00 pm.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	SURVEY LETED
D 148110	R <b>/22/2014</b>
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
KANNON CREEK ASSISTED LIVING  1808 N CANNON BOULVARD  KANNAPOLIS, NC 28083	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358  Continued From page 61  -Staff documented the administration of Cogentin 1mg daily from November 1, 2014 through December 21, 2014.  Observation on 12/19/14 at 4:30 pm of Resident #7's medications on hand at the facility revealed Cogentin was not available for administration.  Interview on 12/19/14 at 4:48 pm with a medication aide on duty revealed:  -The resident was out of the Cogentin medicationShe was unable to locate a refill requestThe last dosage must have been administered yesterdayWhen there were 2-3 dosages left, the medication Aide on duty should have requested a refill.  Interview on 12/22/14 at 9:20 am with the dispensing pharmacy staff used to fill Resident #7's medications revealed: -Cogentin 1mg daily was dispensed for quantity of 30 on 10/13/14 and 11/10/14The medication was not on automatic refill and the facility had to request the medication be re-filledBased on the dispensing history of the medication it would have run out around December 10-13, 2014As of today, December 22, 2014 the facility had not requested a refill of the medication.  Interview on 12/22/14 at 9:43 am with the Resident Care Coordinator revealed: -Resident #7 should not have run out of the CogentinShe did not know what to say regarding why staff did not reorder the medication according to the	

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STATE FORM 6899 O3GX11 If continuation sheet 62 of 159

Division of	of Health Service Regu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					F	₹
		HAL080003	B. WING		12/2	2/2014
NAME OF D		OTDEET AS	DDEGG OITY OTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N C	ANNON BOULV	ARD		
MAINTON	ONLEN ACCIONED LIVIN	KANNAP	OLIS, NC 28083	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	. 62	D 358			
D 330	Continued From page	5 02	D 330			
	Based on record review	ew, observation and attempt				
	interview on 12/17/14	and 12/19/14 it was				
	determined that Resid					
	interviewable.	dent iii was not				
	interviewable.					
	4 Poviou of Pooido	nt #7's current FL2 dated				
		ii #7 \$ current FL2 dated				
	05/1/14 revealed:	Part de la la companya de la company				
		diabetes, chronic obstructive				
		enal insufficiency and				
	anemia.					
		Stick Blood Sugar (FSBS)				
	daily before meals an	nd at bedtime.				
	-Humalog Insulin (A f	asting acting insulin that is				
	used to lower blood g	lucose level) parameter				
	sliding scale (SSI) 4 t					
	-FSBS 62-150= 0 ur					
	-FSBS 151-200=2 u					
	-FSBS 201-250=4 u					
	-FSBS 251-300=6 u					
	-FSBS 301-350-8 ur					
	-FSBS 351-400=10					
	-FSBS greater than	400 notify the physician.				
	Review of Resident #					
	-Hospital discharge s	ummary report dated				
	10/25/14.					
	-Discharge medicatio					
	subcutaneously with	sliding scale three times				
	daily before meals (g	reater than 150 = 2 units,				
	+50 = + 2 units).					
	Review of Resident #	7's November 2014 Blood				
	Glucose Record reve	aled:				
		cheduled four times a day at				
	7:00 am, 11:00 am, 5	<del>_</del>				
	-FSBS's range from 8					
		occurrence Humalog SSI				
		orrectly as ordered by the				
	physician as follows:	5050 040 1:				
	-On 11/5/14 at 11:00	am FSBS 219 No				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
		HAL080003	B. WING		R 12/22	2/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	12/22	12014
		1808 N CA	NNON BOULV			
KANNON	CREEK ASSISTED LIVIN	G	LIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 63	D 358			
	documentation Human should have received -On 11/14/14 at 5:00 units of Humalog SSI unitsOn 11/15/14 at 5:00 units of Humalog SSI 4 unitsOn 11/18/14 at 9:0 documention of Human should have received -On 11/19/14 at 11:00 units of Humalog SSI unitsOn 11/20/14 at 11:00 units of Humalog SSI unitsOn 11/28/14 FSBS Humalog SSI should -No documentation the	log SSI was administered 4. 0 pm FSBS 242 received 6 and should have received 4 0 pm FSBS 220 received 6 and should have received 0 pm FSBS 175 no alog SSI administered				
	Glucose Record reve -FSBS testing was so 7:00 am, 11:00 am, 5 -FSBS's range from 9 -Documentation 5 occ administered incorrect physician as follows: -On 12/5/14 at 9:00 units of Humalog SSI unitsOn 12/13/14 at 7:00 documentation Huma should have received -On 12/14/14 at 5:00	theduled four times a day at 1:00 pm, and 9:00 pm. 1:00 to 318. Currence Humalog SSI was 1:00 pm FSBS 249 received 6 should have received 8. Currence 1:00 pm FSBS 186 no 1:00				

units.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
ANDILAN	or connection	IBENTII IOATION NOMBER.	A. BUILDING: _		OOWII EL	_1_0
		HAI 000002	B. WING		R	
		HAL080003	<u> </u>		12/2	2/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
KANNON	CREEK ASSISTED LIVIN	IG .	NNON BOULV DLIS, NC 28083			
0/0.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	<del>.</del>	PROVIDER'S PLAN OF CORRECTION	N.	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 64	D 358			
	-On 12/15/14 at 5:00 documentation of Hurshould have received -On 12/18/14 at 5:00 units of Humalog SSI unitsNo documentaion the 5 doses of Humalog Sincorrectly as ordered Based on record revisiterview on 12/22/14 #7 was not interview at Interview on 12/22/14 medication aide reveal-She relied on the Medication of Human State of Hum	D pm FSBS 230 no malog SSI administered 4 units. D pm FSBS 223 received 2 should have received 4 e physician was notified the SSI were administered d. ew, observation, and attempt t, it was determined Resident able. A at 9:00 am with a aled: edication Administration ermine how much insulin to				
	the SSI parameters for -She said if a residen	t does not want the full ording to the SSI orders " I				
	-If a resident can tell are not confused, " I I -She documented on of insulin she adminis -She stated she does every time the reside	me how they feel and they isten to them." the MAR the actual amount stered to the resident. Inot notify the physician in refused the insulin or ed only partial amounts of				
	the facility Nurse Pra -She was aware Resi coverage 4 times dail -She was not aware t	dent #7 was on SSI with y. he facility were dosage of insulin to the				

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STATE FORM 6899 O3GX11 If continuation sheet 65 of 159

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		, ,	E SURVEY PLETED
		HAL 000000	B. WING	<del></del>		R
		HAL080003	B. WING		12	2/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N C	ANNON BOULVAR	D		
TOAITION	OKEEK AGGIOTED EIVIK	KANNAF	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 65	D 358			
	follow the SSI parame physician or contact t not compliant with the	if the facility had contacted				
	the facility Registered -She was aware som the amount of insulin requested a different administeredShe said the facilty sphysician every time.	e residents were refusing they were to receive and amount of insulin staff were to notify the a resident requested a slin or refused insulin as				
	administering partial of residents per the residents per the residence said the facility proders the physician I she assumed the Marphysician orders for the same of the same	d: Medication Aides (MA) were dosage of insulin to the dent request. colicy was to follow the had written. As were following the he sliding scale insulin nistered the correct amount				
	doses of insulin be ad different from the SSI physicanShe said the facility pasked for a partial do	•				

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STATE FORM 6899 O3GX11 If continuation sheet 66 of 159

STATEMENT OF CERRICATION IDENTIFICATION NUMBER:  HALGEORGE  R  R  180 N CANNON DELLER  STREET ADDRESS, CITY, STATE, 2IP CODE  1808 N CANNON BOULVARD  KANNON CREEK ASSISTED LIVING  SUMMARY STATEMENT OF DEPICIENCES  1808 N CANNON BOULVARD  KANNON CREEK ASSISTED LIVING  SUMMARY STATEMENT OF DEPICIENCES  (PACH DEPICIENCY MUST BE PRECEDED BY PULL)  THE CRUSS ART FERENCE CORRECTIVE ACTION SHOULD BE CROSS ART FERENCE CORRECTION SHOULD BE CROSS ART FERENCE CORRECTIVE ACTION SHOULD BE C	DIVISION	n nealth Service Regu	lation			
MALE OF PROVIDER OR SUPPLIER  **RANNON CREEK ASSISTED LIVING**  **RANNON RECK ASSISTED LIVING**  **RANNON RECK ASSISTED LIVING**  **SUMMUNY SYNTEMENT OF DEPOSENCES**    FROM I CANNON BOULVARD KANNAPOLIS, NC 20083**    MAN   D			1 ' '			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1880 NE CANNON BOULVARD KANNON CREEK ASSISTED LIVING  SUMMANY STATEMENT OF DEPRESSACION SANDAMANY SAN	AND PLAN (	ND BLAN OF CORRECTION IDENTIFICATION NUMBER		COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1880 NE CANNON BOULVARD KANNON CREEK ASSISTED LIVING  SUMMANY STATEMENT OF DEPRESSACION SANDAMANY SAN						
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1888 N CANNON BOULVARD  KANNAPOLIS, NC 28083   DAY  SUMMARY STATEMENT OF DEFICIENCIES  (#ACH DEFICIENCY MUST BE PRECEDED BY FULL PRETIX  TAG  CROSS-REFERENCED TO THE APPROPRIATE  D 358  Continued From page 66  MAR and call the physicianShe said the MA can not administer insulin per the resident request without an orderShe said the facility had an inservice for insulin administration a few weeks ago.  B. Interview on 12/17/14 at 10:22 am with Resident #80 turing the tour of the facility revealed: -She had severe nerve damage in her right leg and was ordered ZanaflexThe beginning of the month she was out of the medication and suffered with painShe was often out of her medications were always running out.  Review of Resident #8's current FL2 dated 10/07/14 revealed: -Diagnoses of seizure disorder, bipolar disorder, nausea, hyper-triglycendemia, chronic neuropathy pain, and dyspepsiaMedication orders included Zanaflex (used to treat pain) 2mg three tablets (6mg) four times dailyReview of Resident #8's November 2014 medication administration record (MAR) revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times dailyReview of Resident #8's December 2014 MAR revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 5 tablets = 6mg four times dailyThe pharmacy printed MAR listed Zanaflex 2mg tablets, take 5 tablets = 6mg four times dailyThe pharmacy printed MAR listed Zanaflex 2mg tablets, take 5 tablets = 6mg four times dailyThe pharmacy printed MAR listed Zanaflex 2mg tablets, take 5 tablets = 6mg four times daily.			1141 00000	B WING		1
TANNON CREEK ASSISTED LIVING   SUMMARY STATEMENT OF DEPICIENCIES   SUMMARY STATEMENT OF DEPICIENCIES   GACH DEPICIENCY MUST BE PRECEDED BY FULL   PREFIX   GEACH DEPICIENCY NUST BE PRECEDED BY FULL   PREFIX   GEACH CORRECTIVE ACTION SHOULD BE DATE   CROSS-REPERRICCED TO INE APPROPRIATE   DATE   DATE			HAL080003	B: Wille		12/22/2014
CANNAPOLIS, NC 28083   ID   PROVIDERS PLAN OF CORRECTION   CANNAPOLIS, NC 28083	NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DATE			1808 N C	ANNON BOLLLV	ARD	
MAIL   SUMMANY STATEMENT OF DEPICENCIES   PRETIX   PROVIDERS PLAN OF CONDECTION   CONCECTION   PRETIX   PROVIDERS PLAN OF CONDECTION   PRETIX   PRETIX   PRETIX   PROVIDERS PLAN OF CONDECTION   PRETIX	KANNON	CREEK ASSISTED LIVIN	G			
D 358  Continued From page 66  MAR and call the physicianShe said the MA can not administer insulin per the resident request without an orderShe said the MA can not administer insulin administration a few weeks ago.  B. Interview on 12/17/14 at 10:22 am with Resident #8 during the tour of the facility revealed: -She had severe nerve damage in her right leg and was ordered ZanaflexThe beginning of the month she was out of the medication and wifered with painShe was often out of her medications and staff did not tell why her medications were always running out.  Review of Resident #8's current FL2 dated 10/07/14 revealed: -Diagnoses of seizure disorder, bipolar disorder, nausea, hyper-triglyceridemia, chronic neuropathy pain, and dyspepsiaMedication orders included Zanaflex (used to treat pain) 2mg three tablets (6mg) four times dailyStaff documented the administration of the medication administration record (MAR) revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times daily.  Review of Resident #8's December 2014 MAR revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times dailyThe pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times dailyThe pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times dailyThe pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times daily.			KANNAF	JLIS, NC 2000	•	
D 358  Continued From page 66  MAR and call the physicianShe said the MA can not administer insulin per the resident request without an orderShe said the facility had an inservice for insulin administration a few weeks ago.  B. Interview on 12/17/14 at 10:22 am with Resident #8 during the tour of the facility revealed: -She had severe nerve damage in her right leg and was ordered ZanaflexThe beginning of the month she was out of the medication and wifered with painShe was often out of her medications and staff did not tell why her medications were always running out.  Review of Resident #8's current FL2 dated 10/07/14 revealed: -Diagnoses of seizure disorder, bipolar disorder, nausea, hyper-triglycendemia, chronic neuropathy pain, and dyspepsiaMedication orders included Zanaflex (used to treat pain) 2mg three tablets (6mg) four times daily. Review of Resident #8's November 2014 medication administration record (MAR) revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times daily.  Review of Resident #8's December 2014 MAR revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times daily.  Review of Resident #8's December 2014 MAR revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times daily.						( - /
D 358  Continued From page 66  MAR and call the physicianShe said the Ma can not administer insulin per the resident request without an orderShe said the Ma can not administer insulin administration a few weeks ago.  B. Interview on 12/17/14 at 10:22 am with Resident #8 during the tour of the facility revealed: -She had severe nerve damage in her right leg and was ordered ZanaflexThe beginning of the month she was out of the medication and suffered with painShe was often out of her medications and staff did not tell why her medications were always running out.  Review of Resident #8's current FL2 dated 10/07/14 revealed: -Diagnoses of seizure disorder, bipolar disorder, nausea, hyper-triglycendemia, chronic neuropathy pain, and dyspepsiaMedication orders included Zanaflex (used to treat pain) 2mg three tablets (6mg) four times daily. Review of Resident #8's November 2014 medication administration record (MAR) revealed: -The pharmacy printed MAR listed Zanaflex Zmg tablets, take 3 tablets = 6mg four times daily.  Review of Resident #8's December 2014 MAR revealed: -The pharmacy printed MAR listed Zanaflex Zmg tablets, take 3 tablets = 6mg four times daily.  Review of Resident #8's December 2014 MAR revealed: -The pharmacy printed MAR listed Zanaflex Zmg tablets, take 3 tablets = 6mg four times daily.		•			,	
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-She said the MA can not administer insulin per the resident request without an order.  -She said the facility had an inservice for insulin administration a few weeks ago.  B. Interview on 12/17/14 at 10:22 am with Resident #8 during the tour of the facility revealed:  -She had severe nerve damage in her right leg and was ordered Zanaflex.  -The beginning of the month she was out of the medication and suffered with pain.  -She was often out of her medications and staff did not tell why her medications were always running out.  Review of Resident #8's current FL2 dated 10/07/14 revealed: -Diagnoses of seizure disorder, bipolar disorder, nausea, hyper-triglyceridemia, chronic neuropathy pain, and dyspepsia.  -Medication orders included Zanaflex (used to treat pain) 2mg three tablets (6mg) four times daily.  Review of Resident #8's November 2014 medication administration record (MAR) revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times daily.  -Staff documented the administration of the medication daily at 5:30 am, 12:00 pm, 4:00 pm, and 8:00 pm.  Review of Resident #8's December 2014 MAR revealed: -The pharmacy printed MAR listed Zanaflex 2mg tablets, take 3 tablets = 6mg four times daily.		MAP and call the phy	reician			
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tablets, take 3 tablets = 6mg four times daily.			d MAR listed Zanaflex 2mg			
-Staff documented the administration of the			-			
medication daily at 5:30 am, 12:00 pm, 4:00 pm,						

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and 8:00 pm.

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	FOF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R
		HAL080003	B. WING		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
KANNON	ODEEK AGGIOTED I IVIN	1808 N C	ANNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	KANNAP	OLIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	67	D 358		
	-Staff documented on	the back of the MAR on 4 the medication was out.			
	#8's medications on h -Review of the dosage	e on the pharmacy printed le revealed 4mg one and mes daily.			
	medication be refilled -The pharmacy contar for a new prescription -The new order dated and one-half tablet for -The pharmacy stated not changed, but the order different based on the pharmacyThe medication was one and one-half table -Facility staff should in as on the MAR, but 60 -The pharmacy said in called to clarify the medicationsAdministering the mediossibly be one reason to last one month.	pense Resident #8's ity called to request the but there were no refills. cted the resident's physician 12/03/14 was for 4mg one ur times daily. I the medication order had dosage amount was tablets available at the dispensed 11/03/14 for 4mg ets quantity 180. ot administer three tablets mg of the medication. o one at the facility had edication dosage dication incorrectly could on why the medication did dispensed on 11/03/14 for and on 12/03/14 for a			
	-If administered accor	ding to dosage instructions bel the medication should			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
						R
		HAL080003	B. WING	<del> </del>	12	2/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N G	CANNON BOULVAI	RD		
	CREEK AGOIGTED EIVIN	KANNA	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 68	D 358			
	Resident #8 revealed -The Zanaflex 2mg w -Some staff gave her daily and some staff gablet four times daily -She did not question what they were doing Interview on 12/18/14 second medication ai -She worked the first Resident #8's Zanafle according to the instribre tabletsShe did not realize the medication read 4mg -The medication dosa checked with the phamake a mistake printition -The person doing the have found the discretion of the condition of the conditio	as what staff gave her. three 3 tablets four times gave her one and one-half a, , she thought staff knew  at at 3:55 pm with the a de revealed: shift and administered ex daily at 12:00 pm auctions printed on the MAR,  the prescription label on the one and one-half tablet. age should have been rmacy to ensure they did not ing the label. the weekly cart audits should expancy and reported it.  at #1's current FL2 dated the sophagitis, dysphagia, ctive disorder, apnea, chronic obstructive unxiety disorder,				
		rostate and emphysema. cluded Prilosec (used to g once daily.				
		1's record revealed an order ilosec 40mg twice daily.				
		1's October, November, and ication administration record				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BOILDING.			
		HAL080003	B. WING		12	R 2 <b>/22/2014</b>
				7/D 00DF	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
KANNON	CREEK ASSISTED LIVIN	IG	CANNON BOULVAR POLIS, NC 28083	ט		
0/0.15	CHMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	COPPECTION	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 69	D 358			
	tablet once daily.	orinted on the MAR as one e administration of the 00 am.				
	#1's medications on head to the dosage per phate 40mg twice daily.	3/14 at 10:32 am of Resident hand at the facility revealed: rmacy printed label was filled on 11/21/14 for a s.				
	#1's medications reversely.  -They had an order d 40mg twice daily.  -The medication was quantity of 120.  -The medication had	staff used to fill Resident				
	#1 revealed: -He had a hernia and -He visited the physic -The physician verba increase the acid mee -The facility has neve amount of the medica doctor did not increas -The current dosage	sian in October 2014.  Ily said that he was going to dication.  It given him an increased ation, so he thought the se the medication.  If Prilosec does not help his sy staff about the medication nem to administer the				
	at Resident #1's phys	at 9:30 am with the nurse sician's office revealed: ne resident in October 2014.				

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DIVISION	n nealth Service Regu	iation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			_			
					R	
		HAL080003	B. WING		12/2	2/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N CA	NNON BOULV	ARD		
MAINION	CICLER ASSISTED LIVIN	KANNAPO	DLIS, NC 28083	<b>S</b>		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
			D.050			
D 358	Continued From page	e 70	D 358			
	The physician did an	endoscope and based on				
		as increased to twice daily				
	to help with the indige					
		entation in their records, no				
	one at the facility had	contacted the physician				
	regarding the residen	t not.				
	-The medication shou	uld be administered twice				
	daily.					
	<b>,</b>					
	Interview on 12/19/14	at 10:35 am with Staff C,				
	(Medication Aide) rev					
	,					
		esident #1 order for Prilosec				
	had changed to twice					
		administered once daily as				
	documented on the M	IAR.				
	-Because the medica	tion only had one entry on				
	the MAR, she was su	re the medication was not				
	administered twice da	aily.				
	-If the medication aide	e administering medications				
		tion label was different from				
		tion aide was to check the				
	resident's record for a					
		was to also contact the				
		dent's physician to see if the				
	order had changed.	John Spriysician to see ii tile				
	•	y'a policy when orders were				
		y's policy when orders were				
		on aide on duty was to write				
		MAR and send the order to				
	the pharmacy.					
		a weekly cart audits to				
		in medications and MAR.				
	-She was unaware ho	ow the order to increase				
	Prilosec had been mis	ssed since October 2014.				
	C. Review of Reside	nt #2's current FL2 dated				
	08/01/14 revealed:					
		diabetes, renal insufficiency,				
		ycemia, and dyslipidemia.				
		finger stick blood sugars) 3				
	times daily.					

Division of Health Service Regulation

STATE FORM 6899 O3GX11 If continuation sheet 71 of 159

Division o	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			_		_	
			B. WING		R	
		HAL080003	B. WING		12/2	2/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
			ANNON BOULV			
KANNON	CREEK ASSISTED LIVIN	IG .	OLIS, NC 28083			
		KANNAP	JLIS, NC 20063	<b>5</b>		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
IAG	REGOLATORY OF	EGG IBERTII TIIVO IIVI GIAWWATIGIV	IAG	DEFICIENCY)	TW/TE	
D 358	Continued From page	e 71	D 358			
	An order for Nevelo	a Inquiin with aliding apole				
		g Insulin with sliding scale				
	` '	nes daily parameters as				
	follows:					
	FSBS 250-300 = 4 ur	/				
	FSBS 301-350 = 6 ur					
	FSBS 351-400 = 8 ur	nits,				
	FSBS 401-450 = 10 ι	units,				
	FSBS 451-500 = 12 t	ınits,				
	FSBS 501-550 = 15 units,					
	FSBS greater than 55	50 notify the physician.				
	Review of Resident #	2's November 2014				
	Medication Administra	ation Records (MARs)				
	revealed:	,				
	- FSBS testing was so	cheduled three times a day				
	at 7:00 am, 11:00 am	<del>_</del>				
	- FSBS values range	•				
	- Documentation SSI					
		ortunities when SSI should				
	•					
	have been administer					
		FSBS=246, documented 5				
	units- should have re					
		FSBS=252, documented 0				
	units, should have red					
		FSBS=267, documented 0				
	units but should have	received 4 units.				
		2's December 2014 MARs				
	from 12/1/14 to 12/18					
	•	cheduled three times a day				
	at 7:00 am, 11:00 am					
	- FSBS values range					
	<ul> <li>Documentation SSI</li> </ul>	was administered				
	-	ortunities when SSI should				
	have been administer	red as follows:				
	- 12/01/14 at 7:00 am	FSBS=334, documented 0				
	units- should have re-					
	- 12/08/14 at 11:00 ar	m FSBS=281, documented 5				
	units, should have red					

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- 12/11/14 at 7:00 am FSBS=250, documented 5

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _	A. BUILDING: COMP	
		HAL080003	B. WING		R 12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	1808 N CA	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	KANNAPO	LIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 72	D 358		
	units, should have red - 12/11/14 at 11:00 ar units, should have red	ceived 4 units, m FSBS=251, documented 5 ceived 4 units, rFSBS=260, documented 0			
	(Hemoglobin A1c test determine blood suga to have diabetes. The Association (ADA) rea	value on 12/06/14 of 7.0. t is a standard tool to ar control in residents known			
	medication aide reveaures. She relied on the Mercord (MAR) to deteat administer to a residency said if a residency and they are not confused the actually administered resident MAR.  She does not docume in nurse progress not	edication Administration ermine how much insulin to ent.  It can tell me how they feel used, "I listen to them." e amount of insulin she to the resident on the ent on the back of MAR or es the reason for ulin outside the parameters			
	shift medication aide - Residents sometime including insulin She routinely docun of the MAR (circle init to document on the b	e refused medications nented refusals on the front tials) and tried to remember ack of the MAR. Resident #2 received his g to physician orders			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING: COMPL	
		HAL080003	B. WING		R <b>12/22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	1808 N CA	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	KANNAPO	LIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 73	D 358		
	the facility Nurse Prault was her expectation follow the insulin slidic ordered by the physic the residents were not she could not recall the office with FSBS particular residents, in Telephone interview of the facility Registered She was aware residented and she was aware som amount of insulin the requested a different She said the facility physician every time partial amount of insulin solutions.	on that the facility would and scale parameters as cian or contact the office if of compliant with the order. if the facility had contacted or insulin changes for including Resident #2.  On 12/22/14 at 12:40 pm with d Nurse revealed: dents in the facility were insulin with parameters. it is to receive and amount.			
	with the Adminstrator -She was aware seve scale insulin with para physicianShe was not aware r administering partial or residents per the resi -She said the facility orders the physician orders for t parameters and admi of insulin that was ordered.	eral residents were on sliding ameters as ordered by the medication aides (MA) were dosage of insulin to the dent request. policy was to follow the had written. A were following the he sliding scale insulin inistering the correct amount dered to the residents.			
	Interview on 12/22/14 Resident Care Coord				

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STATE FORM 6899 O3GX11 If continuation sheet 74 of 159

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R
		HAL080003	B. WING		12/22/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV		
24.0.15	CHMMADV CT		, 		1 000
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 74	D 358		
D 358	-She was aware sever scale insulin with para-She was aware residences of insulin be addifferent from the sliding ordered by the physical conditions and the facility pasked for a partial donot to give it, they we MAR and call the physical conditions and the resident request was as a said the facility padministration of insuling the was aware he was aware	eral residents were on sliding ameters.  Idents were requesting partial diministered that were ing scale parameters sian.  Poolicy was, if a resident se of insulin the MAs were re to document refused on sician.  In not administer insulin per without an order.  Inad an inservice for the lin a few weeks ago.  In at 2:30 pm with Resident setic for a long time.  It as receiving 2 types of any and one short acting.  It both scheduled and on a sed the evening meal time gar was low (around 120 or a concerned his blood sugar and in the edit of the concerned his blood sugar are did not eat much of the concerned his refusals.  In 12/18/14 at 4:25 pm with the concerned coordinator.  In at 4:25 pm with the coordinator revealed:  It is a the coordinator revealed:	D 358		
	documentation (holes	· · · · · · · · · · · · · · · · · · ·			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL080003	B. WING		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
			NNON BOULV		
KANNON	CREEK ASSISTED LIVIN	IG .	LIS, NC 28083		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 75	D 358		
	no system in place to monitor for notifying the prescriber for refusals.				
	The facility provided a follows:	a Plan of Protection as			
		with medication concerns			
		nsure medications are			
	available per the phys				
	<ul><li>All appropriate staff will be trained with return demonstration as warranted.</li><li>Audits will be completed by the Administrator or</li></ul>				
	_	random records daily for 3			
	_	or 4 weeks, and random			
	monthly checks there	eaπer. ken to the executive Quality			
	Assurance committee	-			
	7 locaranos committos				
	CORRECTION DATE VIOLATION SHALL N 5, 2015.	FOR THE TYPE B NOT EXCEED, FEBRUARY			
D 367	10A NCAC 13F .1004 Administration	4(j) Medication	D 367		
	(j) The resident's me	Medication Administration dication administration			
	record (MAR) shall be following:	e accurate and include the			
	(1) resident's name;				
	. ,	cation or treatment order;			
	. ,	ge or quantity of medication			
	administered;	ministering the medication			
	or treatment;	ministering the medication			
		tion for the administration of			
	•	nents as needed (PRN) and			
	documenting the resu	ulting effect on the resident;			
	(6) date and time of a				
	(7) documentation of	any omission of			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I LAN O	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIT LETED	
		HAL080003	B. WING		R <b>12/22/2014</b>	
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KANNON (	CREEK ASSISTED LIVIN	G	NNON BOULV LIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
	omission, including re (8) name or initials of the medication or treasignature equivalent the documented and main administration record. This Rule is not met Based on observation reviews, the facility fathe Medication Admin of 8 residents (Residents (Re	nents and the reason for the efusals; and, the person administering atment. If initials are used, a to those initials is to be intained with the medication (MAR).  as evidenced by: as, interviews and record illed to assure accuracy of inistration Record (MAR) for 5 ents #1, #4, #6, #7, and #9).  Int #4's current FL2 dated peripheral neuropathy and 0/325 mg tablet (A arcotic and acetaminophen are to severe pain) every six N) for pain.  In at 9:30 am with Resident erco 10/325 mg tablet every 6 in. In an out of her pain medicine every 6 in. In a the top in the top in medicine every 6 in. In a the top in the top in medicine every 6 in. In a the top in the top in medicine every 6 in. In a the top in the top in medicine every 6 in. In a the top in the top in medicine every 6 in. In a the top in the top in medicine every 6 in. In a the top in	D 367			

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STATE FORM 6899 O3GX11 If continuation sheet 77 of 159

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					_	
			B. WING		R	
		HAL080003	B. WING		12/2	2/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE. ZIP CODE		
		1808 N CA	NNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	IG .	OLIS, NC 28083			
			JEI3, NC 2000.			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
1,10		,	1,710	DEFICIENCY)		
D 367	Continued From page	e 77	D 367			
	documented as signe	ed out the month of October				
	to Resident #4.					
	Review of Resident #	4's November 2014 MAR				
	revealed:					
	-Documentation on th	ne MAR indicated Norco				
	10/325 mg tablet was	administered 30 times				
	during the month of N	lovember.				
	-Three pages of conti	rol substance sheets for a				
	total of 89 tablets of N	Norco 10/325 mg were				
	documented as signe	ed out for the month of				
	November to Resider					
	Review of Resident #	4's current December 2014				
	MAR revealed:					
	-Documentation on th	ne MAR indicated Norco				
	10/325 mg tablet was	administered 17 times from				
	12/1/14 to 12/17/14.					
	-A control substance 12/1/14 to 12/9/14.	sheet was unavailable from				
		sheet from 12/10/14 to				
		es of Norco 10/325 mg				
		as signed out to Resident #4.				
		io oigilou out to i tooluolit // ii				
	Observation of Resid	ent #4's medications on				
	hand on 12/17/14 at 3	3:30 pm revealed.				
		ed dispensed card with 30				
	dispensed Norco 10/3					
	remaining tablet of N					
		very 6 hours as needed for				
	pain.	,				
		enerated dispensed card of				
		tablets with 30 remaining				
	•	give 1 every 6 hours as				
	needed for pain.	-				
	•	the dispensed date 12/1/14.				
	Intension 5 - 40/40/4	40.40 and with				
	Interview on 12/18/14					
	medication aide (MA)	revealed.			ļ	

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-She said she documented on the front of the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _	A. BUILDING:		ובט
		HAL080003	B. WING		12/2	2/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
	00551/ 40010750 I N/IN	1808 N CA	NNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	IG KANNAPC	LIS, NC 28083	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 367	Continued From page	e 78	D 367			
	requesting pain medic scheduled. -She said it was the r	the MAR if a resident was cation that was not esponsibility of the MAs to r empty spaces "holes"				
	Resident Care Coord -She was aware docu on going problem in t -She said the facility pan inservice in Noven regarding proper docu administration of med -She said the facility pinservice on administ medications in Octob -She said the MAs she every shift for empty -She said when the M control substance she ARCC to fileShe was aware the f system in place for for	pharmacist had conducted onber 2014 for the MAs umentation and dications. Incree had conducted an aration and documentation of er 2014. Incomplete the conducted the mark blocks "holes". If the conducted an aration and documentation of er 2014. Incomplete the conducted an aration and documentation of er 2014. Incomplete the conducted an aration and documentation on a deet they give it to her or the aracility did not have a current allowing-up the trol substance on the MAR artion on the control				
	a second MA reveale -She did recall signing tablets for Resident # control substance cou -She was aware that out the control substat just documenting on the	g out Norco 10/325 mg 4 on the MAR and on a unt sheet. some MAs were not signing ance on the MAR, they were the control substance count				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL080003	B. WING		R <b>12/22/2014</b>
					IE/EE/EVIT
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA		
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV		
	Г	KANNAPO	LIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 79	D 367		
	because, "we are just -She said it was the of to check for "holes" in -She recently realized narcotic count sheet to Refer to review of the Documentation Inspet by the facility contract Refer to interview on the Resident Care Constant Refer to interview on 3:00 pm with the ARC Coordinator).	too busy". Incoming MA's responsibility in the MARs. If she was not comparing the to the accuracy of the MAR. Incomplete on 11/17/14 to the total to the accuracy of the MAR. Incomplete on 11/17/14 to the total			
	contract pharmacy co				
	Refer to telephone int am with a medication	terview on 12/19/14 at 10:30 aide.			
	Refer to telephone into am with the Facility N	terview on 12/19/14 at 11:45 lurse.			
	Refer to second interview with the ARCC on 12/22/2014 at 10:15 am.				
	8/1/2014 revealed: -Diagnoses included hypertension, chronic disease, hepatitis C, i chronic neck and bac abuse, myofascial pa abuse, history of suic	bipolar, anxiety, c obstructive pulmonary insomnia, depression, k pain, history of cocaine in syndrome, polysubstance ide attempt, sciatica, urinary			

anemia.

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DIVISION	n nealth Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			D WING		R	
		HAL080003	B. WING		12/22	2/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE. ZIP CODE		
		1808 N C/	NNON BOULV	APD		
KANNON	CREEK ASSISTED LIVIN	IG .	OLIS, NC 28083			
		KANNAPO	JLIS, NC 2000.	<b>3</b>		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG		200.022	IAG	DEFICIENCY)		
					<del></del>	
D 367	Continued From page	e 80	D 367			
	-An order for Dilaudid	I 4 mg 1 tablet every 6 hours				
	as needed for pain. (I	Dilaudid is a narcotic pain				
	reliever.)	•				
	,					
	Interview on 12/17/14	at 8:45 am with Resident				
	#9, during initial facilit	ty tour revealed:				
	-Has had problems ge					
	· · · · · · · · · · · · · · · · · · ·	especially on 2nd and 3rd				
	shift.	sopeolarly on zha ana ora				
	-The staff told him the	ev were out of the				
	medication.	by were out or the				
		and they told him he should				
	have another week's					
		staff and remind them to give				
	it to him.	stall and remind them to give				
		e to him and asked if he				
		e to fillifi and asked if the				
	needed it.					
	Review of Resident #	'O's record revealed				
		records documented 120				
	10/3/2014.	ng were dispensed on				
	10/3/2014.					
	Paview of Pacident #	9's Control Substance				
		for Dilaudid 4 mg dispensed				
	10/3/2014 documente	<del>-</del> •				
		7/2014 to 10/22/2014.				
	auministered nom 10	7772014 (0 10/22/2014.				
	Review of Resident #	9's October 2014 MAR				
	revealed:					
		4 mg 1 tablet every 6 hours				
	as needed.	and the state of t				
		22/2014, there were 31				
	Dilaudid 4 mg tablets	•				
		dent #9. (29 Dilaudid 4 mg				
		4-10/22/2014 signed out on				
		ocumented on the MAR).				
	-No Control Substance					
	available for the addit	tional 60 tablets dispensed	1			

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on 10/3/2014.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A RUIL DING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:		 	,	
		HAL080003	B. WING		1	2/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N CA	NNON BOULV	ARD		
		KANNAPO	LIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 81	D 367			
	administered from 10 Review of Resident # revealed: -From 11/1/2014-11/7 4 mg tablets docume: -No Control Substance available from 10/22/2 -It could not be deterred dispensed on 10/3/20 administered or accord Review of Resident # pharmacy dispensing tablets of Dilaudid 4 r 10/28/2014.  Review of Resident # Count Sheet for Dilaudious Sheet for Dilaudious from 11.  Review of Resident # revealed: -From 11/7/2014-11/2 Dilaudid 4 mg tablets administered to Resident # revealed: -It could not be deterred to the series of	elets were documented as //22/2014-10/30/2014.  9's November 2014 MAR  //2014, there were 9 Dilaudid ented as administered.  De Count Sheet was 2014-11/7/2014.  Inined that 35 Dilaudid 4mg, enter appropriately unted for.  9's record revealed records documented 120 eng were dispensed on  9's Control Substance enter 30 tablets were //7/2014 to 11/22/2014.  #9's November 2014 MAR  #2/2014, there were 26 documented as dent #9. (4 Dilaudid 4 mg 4-11/22/2014 were not 10 on the MAR).  Inined if Resident #9 as ordered.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL080003	B. WING		R <b>12/22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE ZIP CODE	
			NNON BOULV		
KANNON	CREEK ASSISTED LIVIN	G	LIS, NC 28083		
			T 20003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 82	D 367		
	from 11/23/2014-11/3 - Eight Dilaudid 4 mg administeredNo Control Substand available from 11/22/2 -From 11/1/2014-11/7 4 mg tablets documer -It could not be deterr dispensed on 11/3/20 administered or accord Interview with Assista Coordinator (ARCC) or revealed: -She was unaware of substance logs were and 11/22/2014- 11/2 -She was not aware of Dilaudid 4mgShe knew that Resid	0/2014 revealed: tablets were documented as  the Count Sheet was 2014-11/25/2014. 1/2014, there were 9 Dilaudid anted as administered. In mined that 76 Dilaudid 4mg, 114, were appropriately unted for.  Int Resident Care for 12/22/2014 at 10:15 am  The where the missing control for 10/23/2014-11/6/2014			
	Refer to interview on the Resident Care Co Refer to interview on 3:00 pm with the ARC Coordinator).	c Control Substance ction completed on 11/17/14 t pharmacist.  12/18/14 at 12:15 pm with cordinator (RCC).  12/18/14 at 12:00 pm and CC (Assistant Resident Care			
	contract pharmacy co	onsultant. terview on 12/19/14 at 10:30			
	am with a medication				

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STATE FORM 6899 O3GX11 If continuation sheet 83 of 159

Division o	of Health Service Regu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	
			B. WING		F	
		HAL080003	D. WING		12/2	2/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
		1808 N C4	NNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	IG	DLIS, NC 28083			
			TIO, NO 2000			
(X4) ID		ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
	i			DEFICIENCY)		
D 007			D 007			
D 367	Continued From page	÷ 83	D 367			
	Refer to telephone inf	terview on 12/19/14 at 11:45				
	am with the Facility N					
	Refer to second inter	view with the ARCC on				
	12/22/2014 at 10:15 a					
	C. Review of Resider	nt #6's current FL2 dated				
	7/16/14 revealed:					
	-Diagnoses included	generalized anxiety, chronic				
	pain, and chronic hep	•				
	1. Record review reve	ealed a physician's order for				
		e daily as needed (Klonopin				
	is used to treat anxiet					
	1					
	Review of the Octobe	er 2014 Medication				
	Administration Record	d (MAR) revealed:				
	-An entry for Klonopin	n 0.5mg take 1 tablet twice				
	daily as needed.					
	-Documentation of Kl	onopin 0.5 mg administered				
	16 times from 10/01/1	14 to 10/31/14.				
	-No documentation of	f Klonopin 0.5 mg				
	administered on 8 day	ys on the MAR.				
	-There were a total of	f 15 Klonopin 0.5 mg tablets				
	documented as admir	nistered from 10/01/14 to				
	10/31/14.					
	1					
		lled Substance Count Sheet				
	from 10/02/14 to 10/1					
	<ul> <li>-A total of 30 Klonopir</li> </ul>	n 0.5 mg tablets were				
	received on 9/26/14.					
		onopin 0.5 mg administered				
	24 times between 10/					
		f 30 Klonopin 0.5 mg tablets				
		nistered from 10/02/14 to				
	10/16/14.					
		olled Substance Count Sheet				
	available for 10/17/14	to 10/26/14.				
			1	1		

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Review of the November 2014 MAR revealed:

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		HAL080003	B. WING		R 12/22/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	1808 N C	ANNON BOULV	ARD	
		KANNAP	OLIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 84	D 367		
	daily as neededDocumentation of Kla 21 times from 11/01/1 -No documentation of 11 days on the MARThere were a total of documented as admit 11/30/14.  Review of the Control from 10/27/14 to 11/1 -A total of 60 Klonopia received on 10/24/14 - Documentation of K daily from 10/27/14 to -There were a total of	f Klonopin administered on f 21 Klonopin 0.5 mg tablets nistered from 11/01/14 to  lled Substance Count Sheet 1/14 revealed: n 0.5 mg tablets were . lonopin administered twice			
	from 11/12/14 to 11/2 -A total of 30 Klonopii received on 11/08/14Documentation of Kloropii and times between 11/2 -There were a total of documented as admit 11/28/14.  Review of the Deceminal and the companion of Kloropii and the companion of the	n 0.5 mg tablets were  onopin 0.5 mg administered (12/14 to 11/28/14. f 30 Klonopin tablets nistered from 11/12/14 to  aber 2014 MAR revealed: n 0.5mg take 1 tablet twice onopin 0.5 mg administered (14 to 12/17/14. f Klonopin administered on			
	-There were a total of	2/12/14, and 12/14/14. f 15 Klonopin 0.5 mg tablets nistered from 12/01/14 to			

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12/17/14.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
			7. BOILBING			D
		HAL080003	B. WING		12	R 2/22/2014
NAME OF P	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
KANNON	CDEEK ACCICTED I IVIA	1808 N C	ANNON BOULVA	RD		
KANNON	CREEK ASSISTED LIVIN	KANNAP	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 85	D 367			
	from 11/29/14 to 12/1 -A total of 30 Klonopii 11/27/14Documentation of Kl 30 times between 11/ -There were a total of documented as admi 12/11/14.  Review of the Contro from 12/12/14 to 12/1 -There were a total of documented as admi 12/18/14.  Observation of medic at 2:00 pm revealed: -Klonopin 0.5 mg was and labeled with Res	on 0.5 mg tablets received on onopin 0.5 mg administered /29/14 to 12/11/14. f 30 Klonopin 0.5 mg tablets nistered from 11/29/14 to lled Substance Count Sheet 8/14 revealed: f 13 Klonopin 0.5mg tablets nistered from 12/12/14 to eations on hand on 12/18/14 s available for administration, ident #6's name. ts remaining of 30 tablets				
	Interview on 12/18/14 #6 revealed: -He had resided at th -He was aware of the -He only received Klotwice a dayHe never received th than twice a dayHe usually requested the day and again 1 r -He received Klonopi scheduled times, so t request the Klonopin twice a day.	e facility for about 1 year. medications he received. mopin 0.5 mg as needed me Klonopin 0.5 mg more d 1 Klonopin 0.5mg during more time before bedtime. n 1 mg 3 times each day at there was no need for him to 0.5 mg more often than				
	Interview on 12/18/14	at 4:00 pm with the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		R <b>12/22/2014</b>
	ROVIDER OR SUPPLIER  CREEK ASSISTED LIVIN	STREET AD	DDRESS, CITY, STA ANNON BOULV OLIS, NC 28083	ARD	12/22/23/14
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 367	revealed: -All narcotics have to physician's prescriptic. Only standing medic contract pharmacy or -Resident #6 had 2 K Klonopin 1mg three ti 0.5mg as needed two-He only received the mg) when he asked from the C Sheets did not reflect dates and times on the The MAs were supping MARs every time pring were given.  Telephone interview of a third shift medication. Sometimes she wou mg to Resident #6 aff would be counted for -Resident #6 was supping to Resident #6 aff would be counted for -Resident #6 was supping to the supping to him when he supping to him when he supping to him when he supping the facility contract Refer to interview on the Resident Care Control Refer to interview on the Refer to interview on the Refer to interview on the Refe	be reordered from a con. ations were sent from the con an auto fill cycle. Ilonopin orders, one for times a day and the Klonopin of times a day. It is a seeded Klonopin (0.5 cor it. coin 0.5 mg administered to controlled Substance Count of the accurate administration of the MARs. Cosed to document on the (as needed) medications. It is a controlled Substance Count of the accurate administration of the MARs. Cosed to document on the (as needed) medications. It is a controlled Substance Klonopin 0.5 the 12:00 midnight, and it the next day. Coposed to receive Klonopin of the next day. Coposed to receive	D 367		

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Coordinator).

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			7. BOILBING			R
		HAL080003	B. WING		12	2/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
KANNON	CDEEK ACCICTED I IVIA	1808 N C	ANNON BOULVAR	D		
KANNON	CREEK ASSISTED LIVIN	KANNAP	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 87	D 367			
	Refer to interview on contract pharmacy co	12/18/14 at 4:10 pm with the onsultant.				
	Refer to telephone interview on 12/19/14 at 10:30 am with a medication aide.  Refer to telephone interview on 12/19/14 at 11:45 am with the Facility Nurse.					
Refer to second interview with the ARCC on 12/22/2014 at 10:15 am.						
	2. Review of Resident #6's current FL2 dated 7/16/14 revealed a physician's order for Ultram 50 mg 1 tablet every 6 hours as needed for chronic pain.					
	hours as neededThere were a total of					
	-An entry for Ultram 5 hours as neededThere were a total of	aber 2014 MAR revealed: 50 mg take 1 tablet every 6 f 11 Ultram 50 mg tablets nistered from 11/01/14 to				
	from 10/29/14 to 11/1 -There were a total of documented as admi 11/19/14There were no additi	lled Substance Count Sheet 9/14 revealed: f 19 Ultram 50 mg tablets nistered from 10/29/14 to  sonal Controlled Substance am 50 mg available for				

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DIVISION	or riealiti Service Regu	ialion			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					_
			5 14/110		R
		HAL080003	B. WING	<del></del>	12/22/2014
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	TE ZID CODE	
NAME OF T	NOVIDEN ON 3011 LIEN		, ,	,	
KANNON	KANNON CREEK ASSISTED LIVING				
		KANNAP	OLIS, NC 28083	3	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	I
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
				DEFICIENCY)	
D 367	Continued From page	88	D 367		
2 00.	Continued From page	. 00	2 00.		
	review.				
	Observation of medic	ations on hand on 12/18/14			
	at 2:00 pm revealed:				
	-Ultram 50mg was av	ailable for administration,			
	and labeled with Resi				
	-There were 11 tablet	s remaining of 30 tablets			
	dispensed on 08/29/1	_			
	-There were 3 bingo punch cards (total of 90 tablets) with a dispense date on 11/12/14 available stored in a file cabinet in the Resident				
	Care Coordinator's of				
	Cale Cooldinator 5 of	iice.			
	Intoniou on 12/19/14	at 9:45 am with Booldant			
	#6 revealed:	at 8:45 am with Resident			
		-11th - f			
	He had lived at the fa				
	-He was aware of the	medications ne was			
	administered.				
	-He could not recall th				
	administered Ultram 5	•			
		Ultram in the last "2 or 3" of			
	months.				
	Interview on 12/18/14	at 4:00 pm with the			
	Assistant Resident Ca	are Coordinator (ARCC)			
	revealed:				
	-All narcotics have to	be reordered from a			
	physician's prescription	on.			
	-Only standing medic	ations were sent from the			
	contract pharmacy on	an auto fill cycle.			
	-Not sure what happened to the missing				
	I	Count Sheets for Resident			
	#6's Ultram.				
		50 mg administered to			
		ontrolled Substance Count			
		the accurate administration			
	dates and times on th				
		osed to document on the			
	iviaks every time prn	(as needed) medications			

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were given.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		, ,	E SURVEY PLETED
			A. BOILDING.			R
		HAL080003	B. WING	<del> </del>	12	2/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
KANNON	CDEEK VOOIGEED I IVIN	1808 N C	ANNON BOULVA	RD		
KANNON	CREEK ASSISTED LIVIN	KANNAP	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 89	D 367			
	a second shift medica -Resident #6 had not at nightThe resident had not Ultram 50 mg since N -Resident #6 received prescription that work  Refer to review of the Documentation Inspect by the facility contract  Refer to interview on the Resident Care Co Refer to interview on 3:00 pm with the ARC Coordinator).	t been administered the November 2014. d a new pain medication and better for him. e Control Substance ection completed on 11/17/14 at pharmacist. 12/18/14 at 12:15 pm with bordinator (RCC). 12/18/14 at 12:00 pm and CC (Assistant Resident Care				
	am with a medication					
	Refer to telephone in am with the Facility N	terview on 12/19/14 at 11:45 Jurse.				
	Refer to second inter 12/22/2014 at 10:15	view with the ARCC on am.				
		ent #7's current FL-2 dated agnoses included diabetes, l edema.				
		7's record revealed a Hydrocodone/APAP 5/325 ours as needed for pain.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		R	
					12/2	2/2014
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA NNON BOULV			
KANNON	CREEK ASSISTED LIVIN	G	LIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	90	D 367			
	[Hydrocodone/APAP 5/325 is a combination of hydrocodone (a narcotic pain reliever) and acetaminophen used to treat moderate to severe pain.].					
	the pharmacy provide - Resident #7 was dis Hydrocodone/APAP 5	pensed 120 5/325 tablets on 09/27/14. ation had been returned to				
	Review of Resident #7's October 2014 and November 2014 Medication Administration Records (MARs) and facility Controlled Substance Count Sheets (CSCS) revealed the following:  - Hydrocodone/APAP 5/325 one tablet every 4 hours as needed for pain was listed on the October 2014 MAR and prn (as needed) listed for administration time.  - The MAR had 16 doses of Hydrocodone/APAP 5/325 documented on the front (for administration) of the MAR and 15 doses documented on the back (for effectiveness) of the MAR from 10/6/14 to 10/31/14.  - The CSCS documentation for Hydrocodone/APAP 5/325 revealed 41 tablets					
	from 10/6/14 to 10/31 - Comparison of the CCSCS sheet revealed of Hydrocodone/APAI documented on Residuo 10/31/14 No reason or justific of Hydrocodone/APAI	October 2014 MAR and I administration of 25 doses P 5/325 tablets was not dent #7's MAR from 10/6/14 ation for the administration P 5/325 as needed and e resulting effect on the				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
			A. BOILDING		_	
		HAL080003	B. WING		12/2	? 2/2014
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZID CODE	1 12/2	2/2014
NAIVIE OF FI	ROVIDER OR SUFFLIER		NNON BOULV			
KANNON	CREEK ASSISTED LIVIN	IG .	NINON BOOLV DLIS, NC 28083			
0/0.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	<del></del>	PROVIDER'S PLAN OF CORRECTION	N.	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	91	D 367			
D 367	Review of Resident # and facility CSCS rev - Hydrocodone/APAP hours as needed for p November 2014 MAR for administration time - The MAR had 10 do 5/325 documented or administration) of the documented on the b MAR from 11/01/14 to - The CSCS documer Hydrocodone/APAP were documented as from 11/01/14 to 11/3 - Comparison of the NCSCS sheet revealed of Hydrocodone/APAI documented on Resid 11/01/14 to 11/30/14 - No reason or justific of Hydrocodone/APAI documentation for the resident was docume Review of Resident #	er's November 2014 MAR realed the following: 2 5/325 one tablet every 4 pain was listed on the R and prn (as needed) listed e. Dises of Hydrocodone/APAP In the front (for MAR and 10 doses lack (for effectiveness) of the D 11/30/14. Intation for D/325 revealed 30 tablets administered to Resident #7 D/14. November 2014 MAR and D administration of 20 doses P 5/325 that were not dent #7's MAR from Exation for the administration P 5/325 as needed and De resulting effect on the Ented for 20 doses. Er's December 2014 MAR	D 367			
	(CSCS) revealed the					
		5/325 one tablet every 4				
	hours as needed for p	pain was listed on the R and prn (as needed) listed				
	for administration time					
		oses of Hydrocodone/APAP				
	5/325 documented or	•				
	administration) of the					
	documented on the background MAR from 12/01/14 to	ack (for effectiveness) of the				
	- The CSCS documer					
		5/325 revealed 15 tablets				

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were documented as administered to Resident #7

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURV COMPLETED	
					R	
		HAL080003	B. WING		12/22/2	014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	ANNON BOULV			
			OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 367	Continued From page	92	D 367			
D 367	from 12/01/14 to 12/1 - Comparison of the NCSCS sheet revealed of Hydrocodone/APAI documented on Resid 12/01/14 to 12/17/14 No reason or justific of Hydrocodone/APAI documentation for the resident was docume  Observation on 12/17 Hydrocodone/APAP sadministration reveals tablets plus 4 tablets in the medication cart  Interview on 12/18/14 medication aide reveals tablets plus 4 tablets in the medication aide reveals tablets plus 4 tablets in the medication aide reveals tablets plus 4 tablets in the medication aide reveals tablets plus 4 tablets in the medication aide reveals tablets plus 4 tablets in the medication aide reveals to the MAR when she as that were not a schedure in the MAR when she as that were not a schedure in the plantage of the plantage o	November 2014 MAR and administration of 5 doses P 5/325 were not dent #7's MAR from ation for the administration P 5/325 as needed and e resulting effect on the inted for 5 doses.  1/14 of Resident #7's 5/325 on hand for ed a full bingo card of 30 remaining on a partial card in the front and the back of diministered pain medication fulled medication for the ered medication for all control erection completed on 11/17/14 the pharmacist.	D 367			
		12/18/14 at 12:00 pm and CC (Assistant Resident Care				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	A. BUILDING:  B. WING  SS, CITY, STATE, ZIP CODE  ON BOULVARD  S, NC 28083  ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		,	
		HAL080003	B. WING		12/2	22/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
KANNON	CREEK ASSISTED LIVIN	IG					
040.15	SLIMMADV ST				<u> </u>	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE	
D 367	Continued From page	93	D 367				
	Refer to interview on 12/18/14 at 4:10 pm with the contract pharmacy consultant.						
	Refer to telephone in am with a medication	terview on 12/19/14 at 10:30 aide.					
	Refer to telephone in am with the Facility N	terview on 12/19/14 at 11:45 lurse.					
	Refer to second inter 12/22/2014 at 10:15 a	view with the ARCC on am.					
	10/07/14 revealed: -Diagnoses included	nt #1's current FL2 dated bipolar affective disorder, ression, chronic low back s.					
	included:	on the FL2 dated 10/07/14 times daily as needed (PRN)					
	needed for anxiety wa administered 34 times -Documentation on the revealed:	d (MAR) revealed: tablet three times a day as as documented on the MAR s from 10/01/14 to 10/31/14.					
	from 10/01/14 to 10/1 to 10/31/14) revealed	e administration of Klonopin					

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-16 entries on the Controlled Substance Count

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL080003	B. WING		12/2	? 2/2014
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZID CODE	1 12/2	2/2014
		1808 N CA	NNON BOULV			
KANNON	CREEK ASSISTED LIVIN	IG .	DLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 94	D 367			
	Sheet were not docur	mented on the MAR.				
	-An entry for Klonopir times a day as needer-Staff documented that 1mg 30 times from 17 -Documentation on the revealed: -6 entries did not documented that 1mg 50 times between 11/30/1429 entries on the Constant of the C	e administration of Klonopin 1/01/14 to 11/30/14. he back of the MAR  ument if the medication was  lled Substance Count Sheet 0/14 revealed: e administration of Klonopin en 11/09/14 through  ntrolled Substance Count mented on MAR.				
	-Klonopin 1mg take 1 needed for anxiety wa 23 times from 12/01/ -Documentation on the revealed:					
	from 12/01/14 to 12/1 -Staff documented the 1mg 47 times betwee 12/17/14.	e administration of Klonopin en 12/01/14 through ntrolled Substance Count				
	Count Sheet it was re	the Controlled Substance evealed: nopin 1mg was administered				

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			7. DOILDING		R	
		HAL080003	B. WING		1	2/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULV			
	Г	KANNAP	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 95	D 367			
	-In November 2014 K administered 35 times documentationIn December 2014 K administered 41 times documentation.  2. Medication orders 10/07/14 included: -Ultram 50mg 2 table daily) as needed (PR  Review of the Octobe Administration Record -Ultram 50mg take 2 as needed for pain wadministered 36 times -Documentation on the revealed:	s without proper PRN  Solution and the current FL2 dated  Its every 8 hours (three times N) for pain.  Ser 2014 Medication and (MAR) revealed:  Itablet =100mg every 8 hours as documented on the MAR is from 10/01/14 to 10/31/14.				
	from 10/04/14 to 10/2 -Staff documented the 100mg 60 times betw 10/26/1435 entries on the Co Sheet were not docur Review of the Novem -Ultram 50mg take 2 needed for pain was administered 30 times -Documentation on the revealed:	e administration of Ultram veen 10/01/14 through ontrolled Substance Count mented on the MAR.  Suber 2014 MAR revealed: tablets every 8 hours as documented on the MAR from 11/01/14 to 11/30/14.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
			A. BOILDING.			D
		HAL080003	B. WING	· · · · · · · · · · · · · · · · · · ·	12	R 2/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATI	E, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N C	ANNON BOULVA	RD		
KANNON	CREEK ASSISTED LIVIN	KANNAP	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 367	Continued From page	96	D 367			
	Review of the Control from 11/06/14 to 11/2 -Staff documented the 100mg 60 times betwee 11/29/1436 entries on the Consider were not documented the 100mg 60 times between 11/29/1436 entries on the Consider were not documented to 11/29/14.	lled Substance Count Sheet 9/14 revealed: e administration of Ultram een 11/06/14 through  Introlled Substance Count mented on the MAR.  ber 2014 MAR revealed: tablets every 8 hours as documented administered 4 to 12/17/14.				
	-Documentation on the back of the MAR revealed: -17 entries did document the effectiveness of the medication.  Review of the Controlled Substance Count Sheet from 12/03/14 to 12/17/14 revealed: -Staff documented the administration of Ultram 100mg 39 times between 12/01/14 through 12/17/1420 entries on the Controlled Substance Count Sheet were not documented on the MAR.					
	Substance Count She -In October 2014 Ultra administered 52 times documentationIn November 2014 U administered 42 times documentation.	am 50mg 2 tablets was s without proper PRN  Itram 50mg 2 tablets was s without proper PRN  Itram 50mg 2 tablets was				
	Interview on 12/19/14 medication aide revea -It was the facility req					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL080003	B. WING		12/2	? 2/2014
KANNON CREEK ASSISTED LIVING 1808 N CA		DRESS, CITY, STA NNON BOULV LIS, NC 28083	ARD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	medication name, reamedicationStaff on each shift was proper PRN documer -They checked to ensithe MAR included: state documentation on the initials, medication and of the medication of the medication because rushed to medicationsWhen she checked Formedications such as co-workers she only lof the MAR and did now makenShe did not check docontrolled substance the MARMost times when addication the controlled substance medication the controlled substance medication the controlled substance medication the MAR.  Refer to review of the Documentation Inspective by the facility contraction.  Refer to interview on the Resident Care Controlled intervie	MAR. the MAR, the date, time, the ason, and the effect of the as to check and ensure nation was done. Sure PRN documentation on aff initials on the front, a back (date, time, staff ame, dosage, and effective the MAR. ing able to always do PRN ase sometimes she was a administered. PRN documentation for Klonopin or Ultram behind cooked for initials on the front ot check the back of the accumentation on the sheet to ensure it matched as she only documented on the sheet because she was donot have time to document.  Control Substance ction completed on 11/17/14 at pharmacist.	D 367			

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Coordinator).

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL080003	B. WING		12	R / <b>22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATI	E. ZIP CODE		
			ANNON BOULVA			
KANNON	CREEK ASSISTED LIVIN	IG .	OLIS, NC 28083			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
D 367	Continued From page	98	D 367			
	Refer to interview on contract pharmacy co	12/18/14 at 4:10 pm with the onsultant.				
	Refer to telephone in am with a medication	terview on 12/19/14 at 10:30 aide.				
	Refer to telephone in am with the Facility N	terview on 12/19/14 at 11:45 lurse.				
	Refer to second interview with the ARCC on 12/22/2014 at 10:15 am.					
	Review of the Control Substance Documentation Inspection completed on 11/17/14 by the facility contract pharmacist revealed a notation in the comment section MAR documention PRN reason, route, timing, and effectiveness were missing some documentation.					
	Interview on 12/18/14 revealed: -She was aware docusubstance was an onfacilityShe had identified the were not doing proper documentationShe requested an inferemember to do PRN reach shift was to che ensure proper PRN nesure proper PRN nesure proper PRN nesure sheet.	at 12:15 pm with the RCC  Immentation of controlled -going problem in the  at some medication aides r PRN medication -service to try and help staff medication documentation. eck behind each other to nedication documentation. mentation had to be in two nd on the controlled  to their job and she did not list had conducted an er 2014 for the MAs				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		R
		HAL080003	B. WING		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	1808 N CA	NNON BOULVA	ARD	
KANNON	CREEK ASSISTED LIVIN	KANNAPO	DLIS, NC 28083	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 367	Continued From page	99	D 367		
	place for reviewing co	lications. ave a current system in ontrol substance on the MAR to the control substance			
	with the ARCC (Assis Coordinator) revealed - She was aware the were documenting co on the MAR.  - The facility had seve clarification and accu - The ARCC and the maintain control drug	d:  MAs (medication aides) Introl substance incorrectly  eral meetings to discuss racy of the MAR's.  RCC were responsible to storage and distribution.  ere responsible to check shift for omissions of			
	a medication aide rev -She was aware that out the control substa just documenting on t sheetShe said some of the narcotics on the contr because, "we are just -She said it was the c to check for "holes" ir -She recently realized narcotic count sheet t	some MA's were not signing since on the MAR, they were the control substance count of MA's only sign out too substance count sheet too busy".  Incoming MA's responsibility of the MAR's. If she was not comparing the too the accuracy of the MAR.			
	documentation of nar	nsultant revealed: ues and concerns related to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE  A. BUILDING:	(X3) DATE SURVEY COMPLETED		
					R
		HAL080003	B. WING		12/22/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULVA	ARD	
	OLIMA A DV. OT		OLIS, NC 28083	DDOWNERS BLANCE CORDER	TION
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 367	Continued From page	e 100	D 367		
	concerns related to d her to conduct an in-s narcotics.	ration was aware of the ocumentation had contacted service on documentation of n-service in November 2014.			
	the facility Registered -She worked in the far-She was aware for a were documenting m MAR'sShe completed an in administration and do homes for the MAs a as well as on 12/4/14 -She said the facility staff and also change	cility 3 days a week. bout 3 months the MAs edications incorrectly on the service on medication ocumentation in adult care and facility staff on 10/15/14			
	at 10:15 am revealed -She was aware the A administration of control on the MARThe facility had sever to discuss clarification -She was unaware of Controlled Substance #6 were atShe attempted to local controlled.	:  MAs were documenting trolled substance incorrectly eral meetings and inservices and accuracy of the MARs.			
D 392	10A NCAC 13F .1008 (a) An adult care hor retrievable record of documenting the receivable.	3(a) Controlled Substances 3 Controlled Substances ne shall assure a readily controlled substances by eipt, administration and ed substances. These	D 392		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			D WING			R
		HAL080003	B. WING		12	2/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	CANNON BOULVAR POLIS, NC 28083	D		
0/A) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	COPPECTION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 101	D 392			
		tained with the resident's order that there can be n.				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility faretrievable record of creceipt, administration controlled substances residents (Residents with orders for control	ns, interviews, and record iled to assure a readily controlled substances for the n and disposition of the s for 6 of 8 sampled #1, #3, #4, #6, #7, and #9) lled substances including ions and narcotic anxiety				
	The findings are:					
	A. Review of Resident #6's current FL2 dated 7/23/14 revealed: -Diagnoses included generalized anxiety, chronic pain, and chronic hepatitis C.					
	Klonopin 0.5mg twice	ealed a physician's order for daily as needed (prn) reat anxiety disorders).				
	daily as needed.	d (MAR) revealed:  n 0.5mg take 1 tablet twice  onopin 0.5 mg administered				
	Count Sheet from 10/ -A total of 30 Klonopii dispensed on 9/26/14					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL080003	B. WING		R 12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV LIS, NC 28083		
(VA) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTIO	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 102	D 392		
	24 times between 10/ -There was no Contro available for 10/17/14	olled Substance Count Sheet			
	-An entry for Klonopir daily as needed.	ber 2014 MAR revealed:  n 0.5mg take 1 tablet twice  onopin 0.5 mg administered			
	21 times from 11/01/1	. •			
	from 10/27/14 to 11/1 -A total of 60 Klonopii dispensed on 10/24/1	n 0.5 mg tablets was 4. onopin 0.5 mg administered			
	Review of the Controlled Substance Count Sheet from 11/12/14 to 11/28/14 revealed:  -A total of 30 Klonopin 0.5 mg tablets were received on 11/08/14.  -Documentation of Klonopin 0.5 mg administered 30 times between 11/12/14 to 11/28/14.				
	-An entry for Klonopir daily as needed.	ber 2014 MAR revealed: n 0.5mg take 1 tablet twice onopin 0.5 mg administered l4 to 12/17/14.			
	from 11/29/14 to 12/1 -A total of 30 Klonopii dispensed on 11/27/1 -Documentation of Klo 30 times between 11/	n 0.5 mg tablets was 4. onopin 0.5 mg administered 29/14 to 12/11/14.			
	from 12/12/14 to 12/1	lled Substance Count Sheet 8/14 revealed: onopin 0.5 mg administered			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL080003	B. WING		R <b>12/22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	,
		1808 N CA	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	IG .	LIS, NC 28083		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 392	Continued From page	e 103	D 392		
	13 times between 12/	/12/14 to 12/18/14.			
	IN/OUT sheet for con narcotic storage file of	pin 0.5 mg for Resident #6			
	#6 on 12/18/14 at 2:0 -Klonopin 0.5 mg was 16 tablets remaining	s dispensed on 11/22/14 with of 30 tablets dispensed. ional Klonopin 0.5 mg for			
	Review of faxed information from the contract pharmacy on 12/18/14 revealed: -Klonopin 0.5 mg 60 tablets were dispensed on 10/24/14Klonopin 0.5 mg 60 tablets were dispensed on 11/22/14.				
	Sheets, and dispension mg from 10/24/14 to	ober, November and trolled Substance Count ng records for Klonopin 0.5 12/17/14, a total of 62 5 mg were unaccounted for.			
	#6 revealed: -He had resided at th -He was aware of the -He only received Klo twice a day.	e facility for about 1 year. medications he received. mopin 0.5 mg as needed me Klonopin 0.5 mg more			
	a third shift medicatio	on 12/22/14 at 9:30 am with n aide (MA) revealed: ld administer Klonopin 0.5			

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		 	1
		HAL080003	B. WING		1	2/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV LIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 104	D 392			
	mg to Resident #6 aft would be counted for -Resident #6 was sup 0.5 mg twice a day as -She did not pay atter last received Klonopir give it to him when he Refer to review of the Documentation Inspe 11/17/14.  Refer to interview on the Resident Care Counter to interview on Medication Aide.  Refer to interview on Assistant Resident Care Counter to telephone into pm with the contract purchase with the facility number of the Period of t	ter 12:00 midnight, and it the next day. Sposed to receive Klonopin is needed. Intion to when the resident in 0.5 mg, she would just it asked for it.  Control Substance ction completed on  12/18/14 at 12:15 pm with coordinator (RCC).  12/18/14 at 10:40 am with a  12/18/14 at 4:00 pm with the fare Coordinator (ARCC).  Iterview on 12/18/14 at 4:10 charmacy consultant.  Iterview on 12/19/14 at 11:45 irse.  It #6's current FL2 dated hysician's order for Ultram 50 cours as needed for chronic  Iterview on 12/14 Medication in the fare 2014 Medication in the fare 2014 Medication in the fare 2014 mg administered 20 in mg take 1 tablet every 6 in mg administered 20 in the fare 20 mg administered 20 in mg administered 20				
	times from 10/01/14 to	<del>-</del>				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:			E SURVEY PLETED	
		HAL080003	B. WING		12	R 2/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULVA	RD		
		KANNAF	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	-An entry for Ultram 5 hours as neededDocumentation of Ultimes from 11/01/14 to 11/11 -Documentation of Ultimes between 10/29/14 to 11/11 -There were no additiced to Count Sheets for Ultram 5 hours as neededNo documentation Ultram 5 hours as neededNo documentation Ultram 10/15/14 to 11/15/15/15/15/15/15/15/15/15/15/15/15/1	tram 50 mg administered 9 to 11/30/14.  Illed Substance Count Sheet 9/14 revealed: tram 50 mg administered 19 1/14 to 11/19/14.  In onal Controlled Substance am 50 mg available for 1/16 mg available for 1/16 mg take 1 tablet every 6 mg t	D 392			
	#6 on 12/18/14 at 2:0 -Ultram 50mg was distablets remaining of 3 -There were 3 bingo for a total of 90 tablet	0 pm revealed: spensed on 08/29/14 with 11 0 tablets dispensed. bunch cards (30 tablets each s) with a dispense date on tile cabinet in the Resident				
	pharmacy on 12/18/1	mation from the contract 4 revealed: blets were dispensed on				
	According to the Octo	bber, November and				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, 561251140		R	
		HAL080003	B. WING		1	2/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	ANNON BOULV			
			DLIS, NC 28083		. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 106	D 392			
	Sheets, and dispension from 11/12/14 to 12/1 Ultram 50 mg were un					
	Interview on 12/18/14 at 8:45 am with Resident #6 revealed: He had lived at the facility for about 1 yearHe was aware of the medications he was administeredHe could not recall the last time he was administered Ultram 50 mg.					
	a second shift medica	on 12/19/14 at 10:25 am with ation aide revealed: requested the Ultram 50 mg				
	Ultram 50 mg since N	d a new pain medication				
	Refer to review of the Documentation Inspe 11/17/14.					
	Refer to interview on the Resident Care Co	12/18/14 at 12:15 pm with cordinator (RCC).				
	Assistant Resident Ca	12/18/14 at 4:00 pm with the are Coordinator (ARCC). 12/18/14 at 10:40 am with a				
	Refer to telephone into pm with the contract p	terview on 12/18/14 at 4:10 oharmacy consultant.				
	Refer to telephone into	terview on 12/19/14 at 11:45 urse.				

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STATE FORM 6899 O3GX11 If continuation sheet 107 of 159

DIVISION	or riealin Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			_		_	
			5		R	
		HAL080003	B. WING	<del></del>	12/2	2/2014
NAME OF D	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON 3011 LIEN		, ,	,		
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV			
		KANNAPC	LIS, NC 28083	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIAIE	DAIL
D 392	Continued From page	e 107	D 392			
	D. Daview of Docider					
	03/1/14 revealed:	t #4's current FL2 dated				
		chronic pain and peripheral				
	neuropathy.	cilionic pain and peripheral				
	-An order for Norco 1	0/325 mg tablets (a				
		arcotic with acetaminophen				
	•	te to severe pain) every six				
	hours as needed (PR					
	Tiodio do ficeded (i i i	it) for pain.				
	Interview on 12/17/14	at 9:30 am and on 12/19/14				
	at 10:10 am with Res	ident #4 revealed:				
	-She had lived at the	facility for 9 years.				
		r with her medications and				
	was able to identify e					
	-She said the facility r					
	medication often.	an out of her pain				
		Norco 10/325 mg tablet was				
		ur times a day for pain				
	control.	ur umes a day for pain				
	-She had all over bod	ly pain avery day				
	,	or her Norco 10/325 mg				
	tablet 3 times a day, r	-				
		e Medication Aides (MA)				
	acted mad when she	asked for her pain				
	medication.					
		ago she asked for her				
		told by a MA she was out of				
	pain medication and v					
		rmacy opened to get her				
	medication.					
		of her Norco for a few days				
	the first part of Decei					
		ninistered her another				
	resident pain medicat	tion a Norco 5/325 mg tablet.				
	-She had taken the N	orco 5/325 mg tablet one				
	time, but it did not hel					
		he documentation the				
		nent the administration of her				
	medications.					

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-The resident said she called her friend (contact

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		12	R 2/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N (	CANNON BOULVAR	RD.		
KANNON	CREEK ASSISTED LIVIN	KANNA	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	pain medicine.  Review of Resident # Medication Administr revealed: -Documentation on the 10/325 mg tablets was during the month of Courseled: -Three pages of contitotal of 89 tablets of Node documented as signed October to Resident # revealed: -Documentation on NovemberThree pages of contimonth of NovemberThree pages of contimonth of NovemberThree pages of contimonth of November for 10/325 mg were doctored.  Review of Resident # MAR revealed: -Documentation on the 10/325 mg tablets was from 12/1/14 to 12/17 -A control record for mg (including the data administered, and question maintained by the factored for the 10/325 mg document for 10/325 mg doc	she was out of Norco, her  44's October 2014 ation Record (MAR)  The MAR indicated Norco as administered 49 times October. The substance sheets with a Norco 10/325 mg were and out during the month of 44.  44's November 2014 MAR  MAR indicated Norco 10/325 mistered 30 times during the The substance sheets for the for 89 tablets of Norco fumented as signed out to  44's current December 2014  The MAR indicated Norco as administered 17 times The cording the Norco 10/325 and administered 17 times The cording the Norco 10/325 and administered 17 times The cording the Norco 10/325 and administered 17 times The cording the Norco 10/325 and administered 17 times The cording the Norco 10/325 and administered 17 times The cording the Norco 10/325 and administered 17 times The cording the Norco 10/325 and administered 17 times The cording the Norco 10/325 and administered 17 times The cording the Norco 10/325 and administered 17 times The cording the Norco 10/325 and administered 17 times The cording the Norco 10/325 and administered 17 times The cordinate the c	D 392			
	Observation of Resid	ent #4's medications on 3:30 pm revealed:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	COMPLETED	
					R
		HAL080003	B. WING		12/22/2014
NAME OF D			DECC CITY CTA	TE 7/D 00DE	1 12/22/2011
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	•	
KANNON	CREEK ASSISTED LIVIN	IG .	NNON BOULV LIS, NC 28083		
			TIS, NC 20003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 109	D 392		
	30 tablets of Norco 10 dispensed with a rem 10/325 mg remaining -Another pharmacy g with 30 tablets of NordispensingBoth labels revealed 12/1/14In the medication roowall contained no add Resident #4The locked control s Resident Care Coordicontained no addition	enerated dispensed card co 10/325 remained for the dispensed dated om a locked narcotic box on ditional Norco 10/325 mg for ubstance file cabinet in the			
Review of the facility Narcotic Cabinet Sign IN/OUT sheet for control substance located in the narcotic file cabinet revealed:  -There was no documentation that narcotics were signed in nor out for Resident #4 before 11/24/14.  -Documentation on 12/1/14 three pharmacy generated dispensed cards of Norco 10/325 mg for a total of 90 tablets were signed in for Resident #4.  -Documentaion on 12/5/14 that 30 Norco 10/325 mg tablets were signed out to Resident #4.  -Documention on 12/15/14 that 30 Norco 10/325 mg tablets were signed out to Resident #4.  -No other documentation that Norco 10/325 mg tablets were signed in or out on the Narcotic Cabinet Sign in/out sheet.  Telephone interview on 12/17/14 at 4:15 pm with the facility dispensing pharmacist revealed: -He had dispensed 120 Norco 10/325 mg tablets					

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for Resident #4.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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			D WING		F	
		HAL080003	B. WING		12/2	22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
		1808 N CA	NNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	G	LIS, NC 28083			
			T. 14C 2000			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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				DEFICIENCY)		
D 000	0 " 15	440	D 000			
D 392	Continued From page		D 392			
		orco 10/325 mg tablets, take				
	1 every 6 hours as ne	eeded for pain.				
	Review of the facility's	s Consolidated Delivery				
		act pharmacy revealed the				
		120 tablets of Norco 10/325				
		14 and 12/1/14 for Resident				
	#4.	14 did 12/1/14 for Resident				
	π¬.					
	Interview on 12/18/14	at 12:00 pm with the ARCC				
	revealed:	·				
	-She was aware the M	MAs were documenting				
	control substance inc					
		ral meetings to discuss				
	clarification and accur	•				
		eadily retrievable records				
		Records) were not completely				
	T	ntity received, dispensed				
		on number for the narcotics.				
	-	readily retrievable record for				
	the accountability for					
	_	325 mg tablets was missing				
	from 12/1/14 to 12/9/	-				
		ing the control substance				
	count sheet to her or	•				
		ile the control substance				
	sheet for 2 or 3 years					
	Silection 2 of 5 years	•				
	Interview on 12/18/14	at 12:15 pm with the RCC				
	revealed:					
		cy delivering Norco 10/325				
	mg tablets for Reside	nt #4 on 12/1/14.				
	-She recalled docume	enting 90 Norco 10/325 mg				
	tablets and placing th	em into the locked narcotic				
	file cabinet in her office	ce.				
	-She recalled giving a	a MA a pharmacy generated				
		Norco 10/325 mg tablets for				
	Resident #4 on 12/1/					
		hich MA she gave the Norco				

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10/325 mg tablet pharmacy dispense card to nor

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		HAL080003	B. WING		R 12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON	ODEEK AGGIOTED I IVIIA	1808 N CA	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	KANNAPO	LIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 111	D 392		
	does she have docur-She said the policy was transactions of narcot cabinet to the MAs.  -She had initated the IN/OUT sheet the end some residents in the stronger control substitute.  Telephone interview of Resident #4's contact-She visited Resident #4's contact-She visited Resident #4 medications she took-She said Resident #4 facility was out of her her another residents a Norco 5/325 mg.  -She had spoken to the Charge (SIC) to ask was medication was not in charge of ordering the She spoken to the ac Resident #4 being with-She said the administration.	mentation of the transaction. vas to obtain 2 signatures for tics from the locked file  Narcotic Cabinet Sign d of November 2014 due to facility were prescribed tance.  on 12/18/14 at 4:30 pm with person revealed: #4 two or three times a  4 was very familiar with the pain medication and offered pain medication which was  ne MA and the Supervisor in why Resident #4's pain in the facility and who was in e medications. dministrator to discuss thout her pain medication.			
	Telephone interview of	on 12/19/14 at 10:30 am with			
	10/325 mg tablet the -She did recall borrow another resident to a first of December 201 out of her Norco 10/3	ent #4 being without Norco first part of December 2014. ving a Norco tablet from dminister to Resident #4 the 4 due to Resident #4 being 25 mg tablet.			
	from another resident	ed a Norco 10/325 mg tablet to to give Resident #4. g a second signature due to			

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STATE FORM 6899 O3GX11 If continuation sheet 112 of 159

DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					<sub>-</sub>	_
			D WING		F	
		HAL080003	B. WING		12/2	22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE. ZIP CODE		
			ANNON BOULV	•		
KANNON	CREEK ASSISTED LIVIN	IG .				
		KANNAP	OLIS, NC 28083	3		T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
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TAG	REGOLATORI ORT	EGO IDENTII TING INI GRAMATIGIV	TAG	DEFICIENCY)	MATE.	
D 392	Continued From page	e 112	D 392			
	horrowing a parcetic t	from another resident.				
	•	g out the Norco 10/325 mg				
	•	•				
		on the MAR and on a				
	control substance cou					
	administered the Nor					
		control substance record				
		ne Norco 10/325 mg from				
	12/1/14 to 12/9/14.					
		ount the control substance on				
	the medication carts of	every shift.				
		at 5:00 pm with the ARCC				
	revealed:					
		dent #4 was out of Norco				
	10/325 mg tablets on	November 30th 2014.				
	-She was aware MAs	were borrowing Norco				
	tablets from another r	resident to administer to				
	Resident #4					
	-She called the pharn	nacy December 1, 2014 to				
		co 10/325 mg tablets were to				
	be delivered to the fa	<del>-</del>				
		days to get the Norco				
	_	the facility for Resident #4.				
		Norco 10/325 mg into the				
		cked narcotic file cabinet.				
	•	readily retrievable record				
		cord) for the accountability				
	of the Norco 10/325 (					
		ity administered and quantity				
	• ,	naintained by the facility from				
	12/1/14 to 12/9/14.					
	Defende modern of 0	Control Cubatas				
	Refer to review of the					
	Documentation Inspe	ction completed on				
	11/17/14.					
	Defeate into 1	40/40/44 -+ 40-40				
		12/18/14 at 10:40 am with				
	the Medication Aide.					
	D 6 4 4 4 4	10/10/11 1 10 1- ""				
	Refer to interview on	12/18/14 at 12:15 pm with	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
,		.52	A. BUILDING:			
		HAL080003	B. WING			R 22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	, ,	
		1808 N C	ANNON BOULVAR	D		
KANNON	CREEK ASSISTED LIVIN	G	OLIS, NC 28083	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 113	D 392			
	the RCC.					
		12/18/14 at 4:00 pm with the are Coordinator (ARCC).				
	Refer to telephone in pm with the contract	terview on 12/18/14 at 4:10 oharmacy consultant.				
	Refer to telephone in am with the facility nu	terview on 12/19/14 at 11:45 irse.				
	5/29/2014 revealed: -Diagnoses included hypertension, and hy-An order for Xanax 1 and 2:00pm.	perlipidemia. mg scheduled at 8:00am 0.5 mg given at 8:00 pm				
	#3 revealed: -She was administered and 2:00pm and Xand-The facility ran out of began utilizing the Xatabs for the 8:00am at 2-"It's rare that you get she made the Admin" why am I even here like I am supposed to She was told by the (RCC) and Assistant (ARCC) that the med from pharmacyShe then called the public told her that it had ne primary care physicial	everything". histrator aware by asking her if I can't get my medicines get". Resident Care Coordinator Resident Care Coordinator ication tote did not come in charmacy herself and they ver been ordered by the				

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	of Health Service Regu				Tara = .== a	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUI	
741012741	or contraction	BERTH IOMITER HOMBER.	A. BUILDING: _		00.0	
					R	
		HAL080003	B. WING		12/22	/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	FE. ZIP CODE		
			ANNON BOULVA			
KANNON	CREEK ASSISTED LIVIN	G	OLIS, NC 28083			
	CLIMMA DV CT				N .	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
D 392	Continued From page	· 114	D 392			
	out and it's time for a	refill".				
	Daview of the Venev	O. F. mary Countralland				
	Review of the Xanax Substance Count She					
	October, November a					
	revealed:	ind December 2014				
		re were 2 tabs signed out on				
	8 separate occurrence	•				
	-	here were 2 tabs signed out				
	on 5 separate occurre	ences.				
	-In December 2014, t	here were 2 tabs signed out				
	on 5 separate occurre	ences.				
	Review of Resident #					
	Medication Administra	ation Record (MAR)				
	revealed: -An entry for Xanax 1	ma schodulad for				
	administration at 8:00	_				
		ax 1 mg was administered				
		onth of October 2014				
	without documented of					
	-Controlled Substance	ce Count Sheets for Xanax 1				
	mg were found to be	missing on dates				
	10/6/2014-10/31/2014	4.				
		ident #3's October 2014				
	MAR revealed:	E ma ashadulad for				
	-An entry for Xanax 0 administration at 8:00	•				
		ocumented as administered				
		onth of October 2014.				
		ce Count Sheets for Xanax				
	0.5 mg were found to					
	10/10/2014-10/31/201	•				
	Deview of Desident #	3's November 2014 MAR				
	review of Resident #	3 S NOVEITIDEL ZU 14 WAR				
	-An entry for Xanax 1	ma scheduled for				

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administration at 8:00am and 2:00pm.

-Xanax 1 mg was documented as administered

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL080003	B. WING		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE. ZIP CODE	
			NNON BOULV		
KANNON	CREEK ASSISTED LIVIN	IG .	LIS, NC 28083		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 115	D 392		
	without documented of Controlled Substancing were found to be 11/1/2014-11/16/2014	e Count Sheets for Xanax 1 missing on dates 1.			
	Further review of the November 2014 MAR revealed: -An entry for Xanax 0.5 mg scheduled for administration at 8:00pm.				
	-Xanax 0.5 mg was documented as administered 30 times during the month of NovemberControlled Substance Count Sheets for Xanax 0.5 mg were found to be missing on dates 11/1/2014-11/2/2014.				
	Review of Resident #3's December 2014 MAR revealed:  -An entry for Xanax 1 mg scheduled for administration at 8:00am and 2:00pm.  -Xanax 1 mg was documented as administered 35 times during the month of December 2014 without documented omissions.  -Controlled Substance Count Sheets for Xanax 1 mg were found to be missing on dates				
	revealed: - Xanax 0.5 mg was of 17 times during the machine -Controlled Substance 0.5 mg were found to 12/7/2014-12/12/2014  Observation of Reside hand on 12/18/14 at 12-A bingo punch card of 18/14 at 13-4 bingo punch card of 18/14 at 14/14 at 14	December 2014 MAR  documented as administered nonth of December. ce Count Sheets for Xanax be missing on dates 4.  ent #3's medications on			

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date of 12/15/2014.

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ובט
	HAL080003 B. WING			R <b>12/22</b>	/2014	
NAME OF D	20/4050 00 01/00/450		DEGG OFF OF	TE 7/D 00DE	, , , , , , ,	,
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV LIS, NC 28083			
OUR MARRY OTATEMENT OF REFLOIDING			1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	: 116	D 392			
		card with the tablet count of The dispense date was				
	12/19/2014 at 4:15 pr -They have had to bo resident ran out of the	sident Care Coordinator on n revealed: rrow because another sir Xanax for a "few days". ntation that the medication				
	was borrowed or returned -We just try to remem	rned. ber to give it back to the				
	resident when the oth substance is delivered					
	-We are working on a	- <del>-</del> -				
	from another resident	rrow control substances				
		at Resident #3 was out of				
	her Xanax 1 mg or 0.					
		missing control sheets are				
	10/6/2014-11/16/2014 12/5/2014-12/15/2014	l, and				
	-Unsure of where the	missing control sheets are				
	for Xanax 0.5 mg duri 10/10/2014-11/2/2014	ng the dates of and 12/7/2014-12/12/2014.				
	-The process is when					
		ntrol substance sheet they RCC to file in their office.				
	•	facility did not have a current				
		ow-up the signing out of				
		the MAR and the matching				
	verification on the cor	trol substance count sheet.				
	-The facility pharmaci					
	inservice in Novembe					
	regarding proper docu					
	administration of med					
	·	d conducted an inservice on cumentation of medications				

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in November 2014.

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DIVISION	n nealth Service Regu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R	
		1141 090003	B. WING		1	
		HAL080003	1		1212	2/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		1808 N CA	NNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	G	LIS, NC 28083			
0411.15	CLIMMADY CT					0/5
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 392	Continued From page	e 117	D 392			
	. •					
	Refer to review of the					
	Documentation Inspe	ction completed on				
	11/17/14.					
	Defeate intensions on	10/10/11 at 10:10 are with a				
		12/18/14 at 10:40 am with a				
	Medication Aide.					
	Refer to interview on	12/18/14 at 12:15 pm with				
	the Resident Care Co					
	the resident oare of	ordinator (100).				
	Refer to interview on	12/18/14 at 4:00 pm with the				
		are Coordinator (ARCC).				
		a. c c c c a a. c . ( c c ).				
	Refer to telephone int	terview on 12/18/14 at 4:10				
	pm with the contract p					
	,	,				
	Refer to telephone int	terview on 12/19/14 at 11:45				
	am with the facility nu	ırse.				
	D. Review of Reside	nt #9's current FL2 dated				
	8/1/2014 revealed:					
	-Diagnoses included	bipolar, anxiety,				
		obstructive pulmonary				
	disease, hepatitis C, i	insomnia, depression,				
		k pain, history of cocaine				
		in syndrome, polysubstance				
	abuse, history of suic	ide attempt, sciatica, urinary				
	retention, diabetes, hy	yponatremia, bursitis and				
	anemia.					
		4 mg 1 tablet every 6 hours				
	· ·	Dilaudid is a narcotic pain				
	reliever.)					
	1545 and 1547 and 1547	D 0.45				
		at 8:45 am with Resident				
	#9 during initial facility					
	-Has had problems go					
		especially on 2nd and 3rd				
	shift.					
	-The staff told him the	ey were out of the				

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medication.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		R	
	HAL080003	B. WING		12/22/2014	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE		
KANNON CREEK ASSISTED LIVING		NNON BOULV OLIS, NC 28083			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
have another week's sulter had to go to the statit to him.  The staff never came to needed it.  Review of Resident #9's logs documented #120 dispensed for Resident Review of Resident #9's count sheet (CSCS) for 10/3/2014 documented administered from 10/7/  Review of Resident #9's Medication Administration revealed:  An entry for Dilaudid 4 as needed.  From 10/8/2014-10/22/ Dilaudid 4 mg tablets diadministered to Resident tablets from 10/8/2014-the CSCS were not documented additional 60 tab 10/3/2014.  Further review of the Odrevealed 13 Dilaudid 4 md documented as administ 10/22/2014-10/30/2014.  Review of the November-From 11/1/2014-11/7/2 4 mg documented as administ and documented as administ and documented as administ 10/22/2014-10/30/2014.	and they told him he should upply remaining. In and remind them to give to him and asked if he spharmacy dispensing Dilaudid 4 mg were #9 on 10/3/2014.  Is facility control substance Dilaudid 4 mg dispensed 60 tablets were 1/2014 to 10/22/2014.  Is October 2014 on Record (MAR)  Imag 1 tablet every 6 hours 1/2014, there were 31 documented as not #9. (29 Dilaudid 4 mg 10/22/2014 signed out on commented on the MAR). In count sheet was available olets dispensed on 1/2014 MAR mg tablets were stered from 1/2014. There were 9 Dilaudid diministered. In count sheet was available	D 392			

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STATE FORM 6899 O3GX11 If continuation sheet 119 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		HAL080003	B. WING		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV		
	T		LIS, NC 28083		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 119	D 392		
	-It could not be deterr	mined that 35 Dilaudid 4mg, 114, were appropriately			
		9's record revealed records documented #120 ispensed for Resident #9 on			
	count sheet for Dilaud 10/28/2014 documen	• •			
	revealed: -From 11/7/2014-11/2 Dilaudid 4 mg tablets administered to Resid tablets from 11/7/201 correctly documented -It could not be deterr received medication a	dent #9. (4 Dilaudid 4 mg 4-11/22/2014 were not I on the MAR). mined if Resident #9 as ordered. e count sheet was available			
	from 11/23/2014-11/3 - Eight Dilaudid 4 mg administeredNo control substance from 11/22/2014-11/2 -From 11/1/2014-11/7 4 mg tablets documed lt could not be deterri	tablets were documented as e count sheet was available 5/2014. 7/2014, there were 9 Dilaudid nted as administered. mined that 76 Dilaudid 4mg, 114, were appropriately unted for.			

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STATE FORM 6899 O3GX11 If continuation sheet 120 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		HAL080003	B. WING		R 12/22	2/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV			
		KANNAPO	DLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 120	D 392			
	Coordinator (ARCC) or revealed: -She was aware the Mocumenting control of MARThe facility had seve to discuss clarification in the substance logs were and 11/22/2014- 11/2 in the substance logs were and 11/22/2014- 11/2 in the substance logs were and 11/22/2014- 11/2 in the substance logs were and 11/21/2014- 11/2 in the substance logs were and 11/21/2014- 11/2 in the substance logs were and 11/22/2014- 11/2	Medication Aides (MAs) were substance incorrectly on the ral meetings and inservice in and accuracy of the MARs. Where the missing control for 10/23/2014-11/6/2014-5/2014. Of Resident #9 running out of dent #9 received it regularly se he set his alarm clock to it.  Control Substance ction completed on  12/18/14 at 10:40 am with a  12/18/14 at 4:00 pm with the pare Coordinator (ARCC).  Iterview on 12/18/14 at 4:10 othermacy consultant.				
		nt #7's current FL-2 dated agnoses included diabetes, edema.				

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STATE FORM 6899 O3GX11 If continuation sheet 121 of 159

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL080003	B. WING		12	R 2/ <b>22/2014</b>
	ROVIDER OR SUPPLIER  CREEK ASSISTED LIVIN	1808 N C	DDRESS, CITY, STATE ANNON BOULVAR POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 392	1. Review of Residen physician's order date 37.5/325 by mouth 3 37.5/325 is a combina acetaminophen used pain.)  Telephone interview of the pharmacy provide - The following disper 37.5/325 for Resident 90 tablets were dispet total of 90 tablets were - No controlled medic the pharmacy for Resident # 2014 Medication Adm and facility Controlled (CSCS) revealed the - Ultracet 37.5/325 or listed on the October for administration at 6 pm.  - Two doses were docadministered on 10/2 - Resident #7 was in 10/25/14.  - Resident #7 receive the October MAR from - No CSCS was avail administration and dis 37.5/325 from 10/25 fidoses not tracked on	at #7's record revealed a ed 07/13/31 for Ultracet times a day. (Ultracet ation of tramadol and to treat mild to moderate  on 12/22/14 at 10:00 am with er revealed: nsing dates for Ultracet tracet, and on 11/21/14 a total of ensed, and on 11/21/14 a total of ensed, and been returned to eident #7.  T's October and November ininistration Records (MARs) at Substance Count Sheets following: ne tablet 3 times a day was 2014 MAR and scheduled 5:00 am, 2:00 pm and 8:00 cumented on the MAR as 2/14.  the hospital from 10/22/14 to dd 19 doses documented on m 10/25/14 to 10/31/14. lable for tracking sposition of Ultracet to 11/03/14 (a total of 30	D 392			
	and facility CSCS rev - Ultracet 37.5/325 or listed on the Novemb					

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STATE FORM 6899 O3GX11 If continuation sheet 122 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			71. BOILBING			
		HAL080003	B. WING		R 12/22/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	IG .	NNON BOULV			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
D 392	the November MAR f - No CSCS was avai administration and dis 37.5/325 from 10/25 f doses not tracked on  Review of Resident # December 2014 MAR 37.5/325 revealed: - Documentation of ar and CSCS for the ren dispensing of 90 on 1 - Documentation of ar and CSCS for the 90 of 77 on 11/21/14 and tablets that remained  Based on observation 12/17/14 and 12/22/1 determined not to be  Refer to review of the Documentation Inspen 11/17/14.  Refer to interview on Medication Aide.  Refer to interview on the Resident Care Co	and 9 doses documented on rom 11/01/14 to 11/03/14. Iable for tracking sposition of Ultracet to 11/03/14 (a total of 30 a CSCS).  To November and as and CSCS for Ultracet diministration on the MARs maining 60 tablets from the 0/21/14. It diministration on the MARs tablets from the dispensing didocumentation for 13 on hand on 12/19/14.  In and attempted interview on 4, Resident #7 was interviewable.  It Control Substance action completed on  12/18/14 at 10:40 am with a 12/18/14 at 12:15 pm with coordinator (RCC).  12/18/14 at 4:00 pm with the lare Coordinator (ARCC).	D 392			
	Refer to telephone in	terview on 12/19/14 at 11:45				

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STATEMEN	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL080003	B. WING		R <b>12/22/2014</b>
		TIAE000003			12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
ΚΔΝΝΟΝ	CREEK ASSISTED LIVIN	1808 N CA	NNON BOULV	ARD	
10-1111011	OKEEK AGOIOTED EIVIK	KANNAPO	LIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 123	D 392		
	am with the facility nu	irse.			
	2 Poviou of Posidor	nt #7's FL-2 dated 05/01/14			
		s order for Ativan 1 mg 3			
		s used to treat anxiety.)			
	Telephone interview of	on 12/22/14 at 10:00 am with			
	the pharmacy provide				
		nsing dates for Ativan 1 mg			
	· ·	0/13/14 a total of 90 tablets			
		on 11/14/14 a total of 90			
	tablets were dispense	eation had been returned to			
	the pharmacy for Res				
	line priarriacy for rece	ndone wit.			
	Review of Resident #	7's October and November			
	2014 Medication Adm	ninistration Records (MARs)			
		Substance Count Sheets			
	(CSCS) revealed:				
	-	et 3 times a day was listed			
		MAR and scheduled for			
		am, 2:00 pm and 8:00 pm. d 19 doses of Ativan 1 mg			
	from 10/16/14 to 10/2	•			
		the hospital from 10/22/14 to			
	10/25/14.	•			
	- Resident #7 receive	d 19 doses of Ativan 1 mg			
		October MAR from 10/25/14			
	to 10/31/14.				
	- No CSCS was avail				
	Ativan 1 mg (quantity	sposition for 60 tablets of			
		/14 to 11/08/14. A total of 60			
	doses were not tracke				
	Review of Resident #	7's November 2014 MARs			
	and facility CSCS rev	<u> </u>			
	_	et 3 times a day was listed			
	on the October 2014	MAR and scheduled for	1		

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administration at 6:00 am, 2:00 pm and 8:00 pm.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 1 2.1.1		.52	A. BUILDING: _			
		HAL080003	B. WING		R 12/22/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV LIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 392	documented on the N 11/01/14 to 11/08/14.  No CSCS was avail administration and dis Ativan 1 mg (quantity 10/13/14) from 10/16. doses were not tracked Continued review of F December 2014 MAF documentation for ad tracking of disposition dispensed by the pha  Based on observation 12/17/14 and 12/22/1 determined not to be Refer to review of the Documentation Inspect 11/17/14.  Refer to interview on Medication Aide.  Refer to interview on the Resident Care Co Refer to telephone int pm with the contract p  Refer to telephone int am with the facility numbers	d 22 doses of Ativan 1 mg lovember 2014 MAR from able for tracking sposition for 60 tablets of of 90 dispensed on /14 to 11/08/14. A total of 60 ed on a CSCS.  Resident #7's November and Res and CSCS revealed ministration on the MAR and for the Ativan 1 mg armacy on 11/14/14.  In and attempted interview on 4, Resident #7 was interviewable.  In Control Substance ction completed on 12/18/14 at 10:40 am with a 12/18/14 at 12:15 pm with pordinator (RCC).  12/18/14 at 4:00 pm with the lare Coordinator (ARCC).  Iterview on 12/18/14 at 4:10 obharmacy consultant.	D 392			
	F. Review of Residen	it #1's current FL2 dated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL080003	B. WING		R <b>12/22/2014</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	G	ANNON BOULV		
			OLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 125	D 392		
	anxiety disorder, depring and osteoarthritism.  1. Medication orders included:	on the FL2 dated 10/07/14			
	anxiety.	times daily as needed for			
	times a day as neede	d (MAR) revealed: n 1mg take 1 tablet three rd (PRN) for anxiety. e administration of Klonopin			
	Review of the Controlled Substance Count Sheet from 10/01/14 to 10/16/14 revealed: -Staff documented the administration of Klonopin 1mg 37 times between 10/01/14 through 10/16/1421 of the 37 entries matched documentation on the resident's MARThere were no Controlled Substance Count Sheets available for 10/17/14 to 10/31/14 to compare with the MAR.				
	-Klonopin 1mg take 1 needed for anxiety wa -Staff documented the 1mg 30 times from 11 Review of the Contro from 11/09/14 to 11/3	lled Substance Count Sheet 0/14 revealed: e administration of Klonopin			
	11/30/14.	matched documentation on			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL080003 B. WING		R <b>12/22/2014</b>		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV			
		KANNAPO	LIS, NC 28083	3	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 392	Continued From page	126	D 392			
		olled Substance Count 1/01/14 through 11/08/14 to Rs.				
	-Klonopin 1mg take 1 needed for anxiety wa	ber 2014 MAR revealed: tablet three times a day as as printed on the MAR. e administration of Klonopin 1/01/14 to 12/17/14.				
	from 12/01/14 to 12/1 -Staff documented the 1mg 47 times betwee 12/17/14.	administration of Klonopin				
	-A quantity of 30 Klon 11/27/14.	Narcotic Cabinet Sign trol substance revealed: opin 1mg was signed out on onopin 1mg was signed any				
	#1's medications on h -Klonopin 1mg was av -The medication was	/14 at 10:32 am of Resident and at the facility revealed: /ailable for administration. labeled with Resident #1's				
	nameThere were 15 tablet packed 30 tablets disp	•				
		/14 at 10:30 am of the ed "brown box" revealed: he overflow box for				

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Review of the faxed "Patient statement" sheet

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
The Bolletines.						
		HAL080003	B. WING		R <b>12/22/2014</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	•	
		1808 N C	ANNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	IG KANNAP	OLIS, NC 28083	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 392	Continued From page	e 127	D 392			
D 392	from the contract pharevealed: -Klonopin 1mg was diguantity of 90, 10/15/11/17/14 for a quantity. Based on October, N December 2014 MAF Count Sheet and "Pathe pharmacy it was of Klonopin 1mg unaccounts. Refer to Control Substinspection completed. Interview on 12/18/14 pharmacy revealed: -Klonopin was not on-The facility had to remedicationThey dispensed Klorog/08/14, 10/15/14, a-As of today's date no back to the facilityFacility documentation medication dispensed. Interview on 12/19/14 #1 revealed: -He lived at the facilityHe shared a room worthe medicationsKlonopin was ordered.	ispensed on 09/08/14 for a 14 for quantity of 90, and on y of 90, total 270.  ovember 2014 and Rs, Controlled Substance tient statement" sheet from determined the total bunted for was 69.  stance Documentation on 11/17/14.  If at 11:10 am with the automatic refill. quest a refill of the mopin for a quantity of 90 on and 11/17/14.  If an endication had been sent on should account for all d.  If at 8:40 am with Resident y a little over one year.	D 392			
	-He sometimes forge	t to ask about the a lot of times he did not need				

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-Some medication aides asked if he wanted the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL080003	B. WING		12	R /22/2014
NAME OF B	DOVIDED OD SUDDUJED		DDEEC CITY CTA	TE ZID CODE	12	122/2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT ANNON BOULVA			
KANNON	CREEK ASSISTED LIVIN	IG .	OLIS, NC 28083			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
D 392	Continued From page	e 128	D 392			
	medication.  -If he said no, they we ask again, but most of at all.  -Staff did not administs.  -Sometimes he got to the morning and in the than that.  -At the most Klonopir 3-4 days per week.  Interview on 12/19/12 (Medication Aide) revelowed a gitated with the resident #1 does becomes agitated with the resident #1 routinels "someone" at the factor order changed from a she was unaware we had been working on changed to routine.  -The facility's process PRN controlled medication the from the back of document on the construction of the construction.  -They checked to ensoon the front, document time, staff initials, me effective of the medications such as medications such as medications such as medications such as medications at the said the medications such as medications.	ould come back later and nedication aides did not ask ter Klonopin to him daily. The medication twice daily in the evening, but never more in was administered to him that 10:35 am with Staff Elealed: The not get Klonopin he shother residents and staff. It is a sheeded (PRN) to routine. The or how long "someone" getting the Klonopin shother than the Allies as needed (PRN) to routine. The or how long "someone" getting the Klonopin shother as to document the MAR, and then the MAR, and then trolled substance sheet. The y's policy that medication behind co-workers to ensure the MAR was initialed that in on the back (date, dication name, dosage, and the trolled substance of the MAR. PRN documentation for Klonopin behind co-workers				
	-When she checked I medications such as	PRN documentation for Klonopin behind co-workers itials on the front of the MAR back of the MAR.				

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controlled substance sheet to ensure it matched

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL080003	B. WING		R 12/2:	2/2014
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 12/2/	172014
	1808 N CA	ANNON BOULVA	•		
KANNON CREEK ASSISTED LIVIN	G KANNAPO	DLIS, NC 28083	3		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392 Continued From page	: 129	D 392			
the MARMost times when adr substance medication the controlled substan always rushed and did on the MARIf there was no docur substance sheet then administeredShe did not know who Resident #1's missing. Refer to interview on Staff C Medication Aid. Refer to interview on Assistant Resident Can Refer to telephone into pm with the contract pm with the facility number of the Medication orders of 10/07/14 included: -Ultram 50mg 2 tablet daily) as needed (PRI Review of the Octobe Administration Recording -Ultram 50mg take 2 that as needed for pain was -Staff documented the	ministering controlled as she only documented on ace sheet because she was a not have time to document mentation on the controlled the medication was not at could have happened to dosages of Klonopin.  12/18/14 at 10:40 am with de.  12/18/14 at 12:15 pm with  12/18/14 at 4:00 pm with the are Coordinator (ARCC).  erview on 12/18/14 at 4:10 obarmacy consultant.  erview on 12/19/14 at 11:45 rse.  on the current FL2 dated  as every 8 hours (three times N) for pain.  r 2014 Medication	D 392			

Division of Health Service Regulation

Review of the Controlled Substance Count Sheet

STATE FORM 6899 O3GX11 If continuation sheet 130 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
			A. BUILDING:			
		1141 000000	B. WING			R
		HAL080003	B. Willo		12	2/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULVA	RD		
		KANNAF	OLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 130	D 392			
D 392	from 10/04/14 to 10/2 -Staff documented the 100mg 60 times betw 10/26/1425 of the 60 times di documentationThere were no Contr Sheets available for 1 and 10/27/14 through the MARs.  Review of the Novem -Ultram 50mg take 2 needed for pain was -Staff documented the 100mg 30 times from  Review of the Contro from 11/06/14 to 11/2 -Staff documented the 100mg 60 times betw 11/29/1424 of the 60 times di documentationThere were no Contr Sheets available for 1 and 11/30/14 to comp	e administration of Ultram reen 10/01/14 through d matched MAR  colled Substance Count 10/01/14 to through 10/03/14 to 10/31/14 to compare with stablets every 8 hours as printed on the MAR. a administration of Ultram 11/01/14 to 11/30/14.  Illed Substance Count Sheet 9/14 revealed: administration of Ultram reen 11/06/14 through d matched MAR	D 392			
	-Ultram 50mg take 2 needed for pain was	tablets every 8 hours as printed on the MAR.				
		e administration of Ultram 12/01/14 to 12/17/14.				
	from 12/03/14 to 12/1 -Staff documented the	e administration of Ultram reen 12/01/14 through				

Division of Health Service Regulation

STATE FORM 6899 O3GX11 If continuation sheet 131 of 159

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING	B. WING		2/2014
	ROVIDER OR SUPPLIER	1808 N CAN	RESS, CITY, STA NON BOULV LIS, NC 28083	ARD	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	-A quantity of 90 Ultra on 12/01/14A quantity of 30 Ultra on 12/03/14.  Observation on 12/18 #1's medications on heading of administrationThe medication was nameThere were 38 tablet 60 tablets dispensed of Comparison on 12/18 narcotic overflow lock of a pack of 60 tablets, was available in the oellow of the faxed from the contract pharevealed: -Ultram 50mg 2 tablet dispensed on 09/16/1 tablets, 10/21/14 for on 11/28/14 for a quandosage 270.  Based on October, No December 2014 MAR Count Sheet and Pati	Narcotic Cabinet Sign trol substance revealed: Im 100mg was signed out Im 100mg was available Im 100mg was available Implication of the Implicat	D 392			

Division of Health Service Regulation

STATE FORM 6899 O3GX11 If continuation sheet 132 of 159

Division of	<u>of Health Service Regu</u>	ılation			
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			_		_
			D WING		R
		HAL080003	B. WING		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
			CANNON BOULV		
KANNON	CREEK ASSISTED LIVIN	NG	POLIS, NC 28083		
			70LIS, NC 20063	T	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAG		,	IAG	DEFICIENCY)	
D 392	Continued From page	e 132	D 392		
	Refer to review of the	Control Substance			
	Documentation Inspe	ction completed on			
	11/17/14.				
	Interview on 40/40/44	1 at 11:10 and with the			
		1 at 11:10 am with the			
	pharmacy revealed:				
		ts every 8 hours was not on			
	automatic refill.				
		d a refill of the medication on			
	09/16/14, 10/21/14, a				
		cation was dispensed for a			
	quantity of 180 tablets	s for 30 day supply.			
	-According to their re-	cords no Ultram had been			
	returned to the pharm				
		•			
	Interview on 12/19/14	4 at 8:40 am with Resident			
	#1 revealed:				
	-He lived at the facility	y a little over one year.			
	-He had chronic back	-			
		ation ordered for him was			
	Ultram.				
		at the medication looked like.			
		for the medication when his			
	back was hurting.	or the medication when the			
		s at the always administered			
	Ultram with Klonopin.				
	-Most of the time he f				
		•			
	medication because h	he did not need the			
	medication.				
		edication daily because his			
	back did not hurt daily				
		administered at the most			
	once daily.				
	-Seldom did he ask fo	or the medication twice daily			
	Interview on 12/19/14	4 at 10:35 am with Staff E,			
	(Medication Aide) rev	ealed:			
	-Resident #1 was abl	le to tell her when he was in			

pain and he knew to ask for pain medication. -Resident #1's Ultram was always administered

STATE FORM 6899 If continuation sheet 133 of 159 O3GX11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		R <b>12/22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULVA		
			OLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 392	Continued From page	e 133	D 392		
	other work betterResident #1 did not a -She was unaware wi the missing dosages	hat could have happened to			
	Refer to interview on the RCC.	12/18/14 at 12:15 pm with			
		12/18/14 at 4:00 pm with the are Coordinator (ARCC).			
	Refer to telephone in pm with the contract p	terview on 12/18/14 at 4:10 oharmacy consultant.			
	Refer to telephone into am with the facility nu	terview on 12/19/14 at 11:45 irse.			
	Inspection completed contract pharmacist re-Control drug declinin incomplete with missi codesControl drug shift chaincomplete with missi-MAR documentation timing, and effectiven documentationControl drug shift chadocumentation of nur	ng count sheet were ng counts and missing  ange forms some were ng signatures. for PRN reason, route, ess was missing some  ange form for accurate nber of sheets was with missing counts noted			

Division of Health Service Regulation

STATE FORM 6899 O3GX11 If continuation sheet 134 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					R	<b>{</b>
		HAL080003	B. WING		12/2	2/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	ODEEK AGGIOTED I IVIIA	1808 N C	ANNON BOULVA	ARD		
KANNON	CREEK ASSISTED LIVIN	KANNAP	OLIS, NC 28083	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	= 134	D 392			
	Interview on 12/18/14	1 at 10:40 am with a				
	Medication Aide reve					
		at the facility since May 2104.				
	_ · · · · · · · · · · · · · · · · · · ·	the front and the back of the				
		nistered pain medication that				
		medication to the resident.				
	-The pharmacy delive	ered medications and				
		well as the Resident Care				
	Coordinator (RCC).					
		icy to sign for all controlled				
	medications.	li4:				
		lication was not needed on				
		hey were placed in the drop ed in the medication room.				
		ned by two MAs and secured				
	_	lication with a rubber band				
	before placed into the					
		had a slot on top of the box				
		e controlled medications.				
	-Only the RCC and th	ne Assistance Resident Care				
	Coordinator (ARCC) box.	had a key to the brown drop				
		RCC were in the facility, the				
	_	ontrolled medications to				
		locked narcotic file cabinet				
	located in their office.					
	Interview on 12/18/14	4 at 12:15 pm with the RCC				
		umentation of controlled				
	substance was an on					
	facility.	genig present in the				
	_	pharmacist had conducted				
		mber 2014 for the MAs				
	regarding proper doc	umentation and				
	administration of med	lications.				
		cted an inservice on 10/9/14			ĺ	
		arcotic sheet documentation.				
	-She was aware the f	facility did not have a current			ļ	

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system in place for reviewing control substances

STATE FORM 6899 O3GX11 If continuation sheet 135 of 159

DIVISION	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		1
					R
		HAL080003	B. WING		12/22/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
KANNON	ODEEK ACCIOTED I IVIN	1808 N CA	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	KANNAPO	LIS, NC 28083	3	
0411.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	1 000
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	· - /
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	
				DEFICIENCY)	
D 392	Continued From page	e 135	D 392		
	on the MAD and then	mentalsing it to the control			
		matching it to the control			
	substance count shee	et.			
	Interview on 12/18/14	•			
	Assistant Resident Ca	are Coordinator (ARCC)			
	revealed:				
	-She had been emplo	yed at the facility for 1 year.			
	-All narcotics have to				
	physician's prescription				
		ations were sent from the			
	contract pharmacy or				
		•			
		sure what happened to the			
	_	ubstance Count Sheets for			
	residents.				
	Telephone interview of	on 12/18/14 at 4:10 pm with			
	the contract pharmac	y consultant revealed:			
	-She found some issu	ues and concerns related to			
	documentation of nar	cotics last month			
		ring the pharmacy review at			
	the facility.	д р, тотто			
		ation was aware of the			
	•	ocumentation and had			
	contacted her to cond				
	documentation of nar				
		n-service in November 2014.			
	•	on 12/19/14 at 11:45 am with			
	the Facility Nurse rev	ealed:			
	-She worked in the fa	cility 3 days a week.			
	-She said she was un	naware of any issues with			
	documentation of nar	cotics until a few months			
	ago.				
	-She completed an in	service on the			
		ocumentation of medications			
		or the MAs and facility staff			
	in October 2014 and				
		had new nursing staff and			
	had also changed the	e nurse station area.			

Division of Health Service Regulation

STATE FORM 6899 O3GX11 If continuation sheet 136 of 159

DIVISION	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		
			D WING		R
		HAL080003	B. WING		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	
TO THE OT THE	NOVIDER OR OUT FIER				
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULV		
		KANNAP	OLIS, NC 28083	3	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE DAIL
				,	
D 392	Continued From page	e 136	D 392		
		a Plan of Protection as			
	follows:				
	-Immediately, all resid				
		will be reviewed to ensure			
	medications are avail	able per the physician's			
	orders.				
	-Count sheets have b	een reconciled and			
	corrected with 2 witne	ess; to ensure counts are			
	accurate.				
	-All residents' medica	tions have been audited to			
	count sheets and med	dication cards have bee			
	reconciled to ensure	counts are accurate.			
	-All appropriate staff v	will be trained on the			
	following process:				
	01				
	-When narcotics are	delivered, the medication			
		y the medications with the			
		ared to the delivery sheets			
	located in the delivery				
		pe required to verify the			
	narcotic counts are co				
		vill be signed and placed in			
	the RCC box in the m	•			
		ved will be placed on the			
	•	entered on the count sheet to			
	ensure continued acc				
		arcotic needs replacing, the			
		e will remove the zeroed out			
		ne control book along with			
		entainer from the medication			
	cart narcotic drawer.	mainer from the medication			
		signee will then put a new			
		neet with each blister pack,			
	bottle, box, or narcotic	on the resident's			
	medication cart.	otio oboot/opents blist			
		otic sheet/empty blister			
	· ·	ill be taken to the RCC			
	office by the RCC and				
	- I he narcotic sheet w	vill then be stapled to the			

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delivery sheet in the secured locked narcotic

STATE FORM 6899 O3GX11 If continuation sheet 137 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		 	,
		HAL080003	B. WING		1	2/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	1808 N C	ANNON BOULV	ARD		
		KANNAP	OLIS, NC 28083	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 137	D 392			
	-The empty narcotic of pharmacy by the RCC or designed narcotics have been pleach packet has a nursecured locked narcotic for the black file cabined in arcotics will be place black file cabined in the Acontrolled substant will also be completed container that has been the Administrator wild documentation and reference compliance.  The audit will be concerted adily times 3 weeks, and random in All results will be taked Assurance committee.	the will verify that the placed in the cart and that sumbered sign in sheet. It is sheet will be placed in the otic cabinet inventory book net and the remaining and in the secured, locked ne RCC office. It is completed for each corresponding and elivered. It complete a narcotic acconciliation audit form to sheet the for 10% of random weeks, then weekly times 4 monthly checks thereafter. It is not the executive Quality as for review.				
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912			
	Every resident shall h 2. To receive care an adequate, appropriate	ration of Residents' Rights nave the following rights: nd services which are e, and in compliance with state laws and rules and				
	This Rule is not met Based on observation					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		HAL080003	B. WING		12	R 2/ <b>22/2014</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
KANNON	CREEK ASSISTED LIVII	1808 N C	CANNON BOULVAR	RD		
KANNON	CREEK ASSISTED LIVII	KANNAI	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D912	interview, the facility resident had the righ services which are a compliance with rule to infection control produced in the findings are:  1. Based on observation review, the facility far appropriate infection implemented for blood regarding the use of 6 residents with order (Residents #2, #10, 17 Tag 932 G.S. 131D-22. Based on observation interviews, the facility medications were add of 7 sampled resident including pain medications were add of 7 sampled resident including pain medications for sliding scation 2 of 2 sampled rorders for sliding scation (Type B Violation)].  3. Based on observative reviews, the facility for the	failed to assure every t to receive care and dequate, appropriate, and in s and regulations as related revention, medication olled substance, and ities.  tion, interview and record itied to assure adequate and control measures were od glucose monitoring shared glucometers for 5 of res for glucose monitoring. #12, #13, and #14.) [Refer to 4.4A(b) (Type B Violation)].  tion, record review and y failed to assure ministered as ordered for 2 res (Residents #7 and #8), ation, anti-anxiety, acid , and antifungal medications, residents with physician's residents	D912			

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STATE FORM 6899 O3GX11 If continuation sheet 139 of 159

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		HAL080003	B. WING		12/22/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
NAIVIL OI 11	NOVIDEN ON 3011 EIEN		NNON BOULV			
KANNON CREEK ASSISTED LIVING			LIS, NC 28083			
	CUMMA DV CT		1			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D912	D912 Continued From page 139		D912			
	reviews, the facility fa services were provide residents in accordan state, and federal reg	ions, interviews and record illed to assure all care and ed by management to ice with all applicable local, ulations and codes. [Refer AC 13F .0603(a) (Type B				
D932	G.S. 131D-4.4A (b) A Requirements	CH Infection Prevention	D932			
	G.S. 131D-4.4A Adult Prevention Requirem	t Care Home Infection ents				
	hepatitis B, hepatitis G pathogens, each adu the following, beginni (1) Implement a writte consistent with the fe Control and Preventic control that addresse a. Proper disposal of to puncture skin, much tissues, and proper dipatient care items that residents.  b. Sanitation of rooms cleaning procedures,	t transmission of HIV, C, and other bloodborne It care home shall do all of ing January 1, 2012: en infection control policy deral Centers for Disease on guidelines on infection is at least all of the following: single-use equipment used cous membranes, and other disinfection of reusable at are used for multiple is and equipment, including agents, and schedules. Section control devices and				
	d. Blood and bodily flue. Procedures to be for home staff is exposed fluids of another persignificant risk of tranhepatitis C, or other but the staff of the staf	uid precautions.  ollowed when adult care  d to blood or other body  on in a manner that poses a  smission of HIV, hepatitis B,  oloodborne pathogens.  ibit adult care home staff				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		12	R 2/22/2014
	ROVIDER OR SUPPLIER  CREEK ASSISTED LIVIN	1808 N C	DDRESS, CITY, STATE ANNON BOULVAR POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D932	engaging in direct responsible for contact be equipment, or device dermatitis until the co (2) Require and monifacility's infection con (3) Update the infection ecessary to prevent	s or weeping dermatitis from sident care that involves the setween the resident, is and the lesion or indition resolves. tor compliance with the trol policy.	D932			
	review, the facility fail appropriate infection implemented for bloo regarding the use of s	n, interview and record ed to assure adequate and control measures were d glucose monitoring shared glucometers for 5 of rs for glucose monitoring. e12, #13, and #14.)				
	Coordinator on 12/17 residents receiving fir checks.  Review of the records receiving finger stick the 29 residents had	nger stick blood sugar  s (FL2s) for residents' blood sugars revealed 2 of a blood borne pathogen r diagnoses (One with				

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STATE FORM 6899 O3GX11 If continuation sheet 141 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		1:	R 2/22/2014
NAME OF F	DOMBED OD OUDDINED			5. 7/D 00D5	12	122/2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT ANNON BOULVA			
KANNON	CREEK ASSISTED LIVIN	G	POLIS, NC 28083	ND		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D932	Continued From page	e 141	D932			
	Immunodeficiency Vir	rus).				
	guidelines for infection recommendations are monitoring devices (gishared between reside be used for more that cleaned and disinfect instructions. If the madisinfection information to be shared between Review of the facility! Disinfection of Glucor recommendations procleaning and decontate that may be contaminated fluids as follows:  - Clean glucometer subloody fluids are presidampened with soap visible organic materials. If no visible organic after each use the eximanufacturer's directive ither an EPA-register a tuberculocidal or Hiddlute bleach solution concentration.  Telephone interview of a representative of the Brand A glucometer mapproved for use on redisinfected, according disinfectant's direction germicidal wipe.	e that blood glucose lucometers) should not be lents. If the glucometer is to n one person, it should be ed per the manufacturer's nufacturer does not list the on, the glucometer should en residents.  Is written Cleaning and meters Policy included ovided for guidance for mination of glucometers hated with blood and body  urface when visible blood or eent by wiping with a cloth and water to remove any al. material is present, disinfect terior surfaces following the ions using a cloth/wipe with red detergent/germicide with BV/HIV label claim or a				

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STATE FORM 6899 O3GX11 If continuation sheet 142 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL080003	B. WING		12	R 2/ <b>22/2014</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		1808 N C	ANNON BOULVAR	RD		
KANNON	CREEK ASSISTED LIVI	NG KANNAF	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D932	a representative of the Brand B glucometer recommended for sin for use on multiple remanufacturer's guide glucometer should not observation on 11/17 day shift Medication and the 100 Hall.  She was working on on the 100 Hall.  She was assisted be Care Coordinator (AI - A resident was sitting medication cart.  The ARCC wrapped wipe and placed it or white paper towels of top of the medication.  The ARCC prepare administered to the recontinued observation opened box of (Brand disposable wipe: The Bactericidal-tuberculor Virus. (The manufact a wipe to thoroughly many as necessary to wet for 2 minutes; all linterview on 12/17/14 and the RCC revealed.  The resident had jublood sugar check.  The FSBS was obtaw rapped in the wipe.  The glucometer (Br	the manufacturer for the revealed the glucometer was agle use only; not approved esidents. (Based on clines the Brand B of be shared.)  7/14 at 11:18 am of Staff D, Aide, revealed: In a medication cart (Cart C)  1//15 y the Assistant Resident (CCC). 1//16 in a wheel chair beside the cline at the top of a small stack of in the right hand side of the cart. 1//16 d an insulin injection and desident. 1//17 in a modern cart revealed and condition are conditionally assistant and condition and condition and condition and condition and condition are conditionally assistant and condition and condition and condition are conditionally assistant and condition and	D932	DE. NOIENCE		

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STATE FORM 6899 O3GX11 If continuation sheet 143 of 159

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING	<del></del>		
HAL	080003	B. WING		R 12/22/2014	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KANNON CREEK ASSISTED LIVING		NON BOULV LIS, NC 28083			
(X4) ID SUMMARY STATEMENT OF DEPARTMENT OF D	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D932 Continued From page 143  - Staff D stated the resident in the not have a glucometer of his owr - Staff were using other residents obtain FSBS checks for the reside chair and any other resident that their own glucometer.  - Staff used the wipes to disinfect glucometers prior to use on a diff.  Observation on 12/17/14 betwee 12:15 pm of the glucometers stormedication carts in the facility resident's name and stored in se bags labeled with the residents'r.  - Cart A had 5 Brand A glucometer a resident's name and stored in se bags labeled with the residents'r.  - Cart C had 6 Brand A glucometer a resident's name and stored in se bags labeled with the residents'r.  - Cart D had 4 Brand A glucometer a resident's name and stored in se bags labeled with the residents'r.  - Cart D had 4 Brand A glucometer a resident's name and stored in se bags labeled with the residents'r.  - Cart E had 2 Brand A glucometer a resident's name and stored in se bags labeled with the residents'r.  - Cart E had 2 Brand A glucometer a resident's name and stored in se bags labeled with the residents'r.  - Cart E had 2 Brand A glucometer a resident's name and stored in second to the previous glucometers (residents' name residents' name residents's name and stored in second to the previous glucometers (residents' name residents's name and stored in second to the previous glucometers (residents' name residents's name and stored in second to the previous glucometers (residents' name residents's name and stored in second to the previous glucometers (residents' name residents's name and stored in second to the previous glucometers (residents' name residents's name and stored in second to the previous glucometers were stock of the previous glucometers were stock of the previous glucometers were stock of the grevious glucometers were stored the glucometers were stores and the glucometers were stored the glucometers were stored the	in a strict of the second of t	D932			

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STATE FORM 6899 O3GX11 If continuation sheet 144 of 159

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					F	,
		HAL080003	B. WING		1	22/2014
					1 -12	.2/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
KANNON	CREEK ASSISTED LIVIN	G	ANNON BOULVA			
		KANNAP	OLIS, NC 28083	i		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG		,	IAG	DEFICIENCY)		
Dogo	0 ( 15	444	D022			
D932	Continued From page	9 144	D932			
	residents receiving ne	ew glucometers in				
	September 2014.					
		ty had not disposed of the				
	glucometers but were	not currently using them.				
		ry of FSBS values stored in				
	_	ucometers (not approved for				
	use on multiple reside					
	- No resident's name glucometer.	was located on the				
	0	I not be verified as set				
	correctly.	Thot be verified as set				
	,	s obtained within a short				
	period of time.	o obtained within a orient				
	•	ding stored in the memory				
	of the glucometer wer	-				
	On 11/12 at 4:21 pm	FSBS=165,				
	On 11/12 at 4:17 pm	FSBS=157,				
	On 11/12 at 4:14 pm					
	On 11/12 at 4:03 pm					
	On 11/12 at 11:01 am					
	On 11/12 at 11:00 am					
	On 11/12 at 10:52 am					
	On 11/12 at 10:48 am					
	On 11/2 at 11:19 am I On 11/2 at 11:15 am I					
	On 11/2 at 11:12 am I	•				
	On 11/2 at 11:12 am I					
	011 11/2 at 11:10 aiii 1	020 100.				
	Refer to interview on	12/17/14 at 11:22 am with a				
	day shift Medication A					
	Defeate int	40/47/44 -1 4:00				
		12/17/14 at 4:20 pm with the				
	Administrator and Ass Coordinator (ARCC).	sistant Resident Care				
	COOTUINATOR (ARCC).					
	Refer to telephone int	erview on 12/19/14 at 10:50				

am with a night shift Medication Aide.

Refer to interview on 12/22/14 at 11:50 am with

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Y
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		R	
		HAL080003	B. WING		12/22/20	14
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1808 N CA	NNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	IG .	DLIS, NC 28083			
			JEI3, NO 2000			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) MPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
1/10		,	IAG	DEFICIENCY)		
D932	Continued From page	e 145	D932			
	the Resident Care Co	oordinator (RCC)				
	the resident oare of	ordinator (100).				
	2 Review of the histo	ory of FSBS values stored in				
		Brand B glucometers (not				
		nultiple residents) revealed:				
	- No resident's name	•				
	glucometer.	was located on the				
	•	d not be verified as set				
		Thot be verified as set				
	correctly.	as obtained within a short				
	•	es obtained within a short				
	period of time.	ive reading stored in the				
		ive reading stored in the				
	, ,	neter were as follows:				
	On 11/05 at 10:56 am					
	On 11/05 at 10:54 am					
	On 11/05 at 7:07 am l					
	On 11/05 at 7:06 am I	•				
	On 11/05 at 7:04 am l	FSBS=100.				
		er guideline the glucometer				
	should not be shared.	•				
	D ( )	10/17/11 1 11 25				
		12/17/14 at 11:22 am with a				
	day shift Medication A	Aide.				
		12/17/14 at 4:20 pm with the				
	Administrator and Ass	sistant Resident Care				
	Coordinator (ARCC).					
		terview on 12/19/14 at 10:50				
	am with a night shift N	Medication Aide.				
		12/22/14 at 11:50 am with				
	the Resident Care Co	oordinator (RCC).				
		t #14's current FL2 dated				
	4/25/14 revealed diag	noses included dementia				
	Alzheimer's type, Sch	nizoaffective disorder, and				
	diabetes.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL080003	B. WING		R <b>12/22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE	
		1808 N CA	NNON BOULV		
KANNON	CREEK ASSISTED LIVIN	G	LIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D932	Continued From page	146	D932		
3002	Review of Resident # physician's orders da (signed but not dated (FSBS) daily schedule	14's record revealed current ted 09/09/14 and 10/14 ) for finger stick blood sugar ed for 7:00 am.			
	labeled with Resident 1:14 pm revealed: - The date displayed correct but the time we current time of day. (A displayed on the glucture - None of the FSBS whistory for December documented on Reside Medication Administration - FSBS values record history were not cons 7:00 am FSBS FSBS values record history were not daily - Multiple FSBS value day with some readin (Based on the manufaction disinfecting wipes, the proper disinfecting word plus time for air drying	ometer was 10:18 am. alues in the glucometer's 2014 matched values dent #14's December ation Record (MAR). ed in the glucometer's istent with the scheduled			
	recorded in a short per glucometer's history was - On 12/17/14 at 8:36 FSBS=330. - On 11/28/14 at 8:13 FSBS=262. - On 11/28/14 at 8:06 FSBS=290. - On 11/15/14 at 8:13	nen multiple FSBS were eriod of time in the Brand A vere as follows: am FSBS=127, at 8:33 am am FSBS=218, at 8:10 am am FSBS=168, at 8:04 am am FSBS=152, at 8:10 am at 8:10 am FSBS=247.			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
7.1101 12.110	or contraction	IDENTIFICATION NOMBERS	A. BUILDING: _			
		HAL080003	B. WING		R <b>12/22/2014</b>	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 12/22/2011	
TVAIVIL OF T	COVIDER OR OUT FEEL		NNON BOULV			
KANNON CREEK ASSISTED LIVING KANNAP			LIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D932	Continued From page	e 147	D932			
D932	- On 11/15/14 at 4:18 FSBS=127, at 4:14 at FSBS=120. (FSBS of to values documented MARs for the corresp Interview on 12/22/14 #14 revealed: - He thought staff alw check his FSBS but hedid not recall see glucometer before or He thought all reside glucometers.  Refer to interview on day shift Medication Assertion Coordinator (ARCC).	am FSBS=111, at 4:16 am m FSBS=72, and at 4:13 am if 127 and 72 corresponded d on 2 other residents' onding time.)  at 3:03 pm with Resident ays used his glucometer to be was not sure. Being the staff cleaning his after use. Bent had their own  12/17/14 at 11:22 am with a laide.  12/17/14 at 4:20 pm with the sistant Resident Care	D932			
	Refer to interview on the Resident Care Co	12/22/14 at 11:50 am with oordinator (RCC).				
	09/15/14 revealed: -Diagnoses included	or Finger stick Blood Sugars				
	labeled with Resident -The date was accura -The time displayed of	of the Brand A glucometer #10's name revealed: ate for the current date. on the glucometer was 1:34 10:39 am, which was 3				

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hours and 5 minutes later than the current time).

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Division of	of Health Service Regu	ılation			FORN	M APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPL	ETED .
		HAL080003	B. WING		1	२ 22/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE		
		1808 N C	ANNON BOULVA	RD		
KANNON	CREEK ASSISTED LIVIN	IG Kannaf	POLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D932	Continued From page	e 148	D932			
	FSBS results documed December 2014 Med Record (MAR).  -FSBS results record history were not dailythe Multiple FSBS results day, and were 3 minute manufacturer's guivipes, the minimum to disinfecting would be time for air drying for Examples of times where of the sum of the gluco dates were identified diabetic residents as -On 12/04/14 at 4:06 am, FSBS=125.  -On 12/04/14 at 8:17 FSBS=156; and at 8:00 12/07/14 at 4:32 FSBS=348; at 4:42 ar FSBS=99; at 4:51 am FSBS=110; at 5:11 an am, FSBS=184.	r December 2014 matched ented on Resident #10's lication Administration  ed in the glucometer's resident was a series or less apart. (Based on uideline for the disinfecting time required for proper 2 minutes wet time plus a total of at least 4 minutes.)  then multiple FSBS were meter history on the same as belonging to other follows:  am, FSBS=103; and at 4:10  am, FSBS=76; at 8:20 am,				

pm, FSBS=99.

-On 12/07/14 at 2:37 pm, FSBS=112; and at 2:40

-On 12/07/14 at 4:25 am, FSBS-100; at 4:26 am, FSBS=231; at 4:30 am, FSBS=135, at 4:32 am, FSBS=149; at 4:34 am, FSBS=178; at 4:37 am, FSBS=371; and at 4:40 am, FSBS=220.
-On 12/11/14 at 4:41 am, FSBS=45; and at 4:44 am, FSBS=84 (result matched FSBS result on the December 2014 MAR for Resident #10).
-On 12/12/14 at 8:02 am, FSBS=345; at 8:05 am, FSBS=234; at 8:11 am, FSBS=163; at 8:14 am,

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DIVISION	n rieaith Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					R	
		HAL080003	B. WING		1	2/2014
		TIALOGOGG			1212	2/2014
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KANNON	CDEEK ACCICTED I IVIN	1808 N C	ANNON BOULV	ARD		
KANNON	CREEK ASSISTED LIVIN	KANNAP	DLIS, NC 28083	3		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
			+	,		
D932	Continued From page	e 149	D932			
	FSBS=197; and 8:16	am, FSBS=292.				
	-On 12/12/14 at 1:09	pm, FSBS=233; at 1:13 pm,				
		m, FSBS=252; and at 1:27				
	pm, FSBS=224.					
	-All above FSBS resu					
		SBS results of 11 different				
	residents for the same	e dates and times.				
	Interview on 12/22/14	at 11:40 am with Resident				
	#10 at revealed:					
	-She had resided at the	he facility for a couple of				
	months.					
	-She did not have her	own glucometer.				
	-Staff checked her blo	ood sugars daily, once in the				
	morning.					
		dents' glucometers to check				
	her blood sugars, become glucometer.	cause she did not have her				
		d to check her blood sugars				
	always had someone					
	-	isinfect the glucometer used				
	on her.	•				
	-She had observed st	aff wipe the glucometer				
	down with a wipe.					
	D ( )	40/47/44 1 44 00				
		12/17/14 at 11:22 am with a				
	day shift medication a	aide.				
	Refer to intervious on	12/17/14 at 4:20 pm with the				
	Administrator and Ass	•				
	Coordinator (ARCC).	Sisterit Nesiderit Gale				
	Coordinator (A100).					
	Refer to telephone int	terview on 12/19/14 at 10:50				
	am with a night shift r					
	Defends interdered	40/00/44 at 44.50				
		12/22/14 at 11:50 am with				
	the Resident Care Co	orumator (RCC).				
	D. Review of Residen	nt #2's current FL2 dated				
		= 5 Jun. J= Galoa	1	I .		

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08/01/14 revealed:

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NAME OF PROVIDER OR SUPPLIER  KANNON CREEK ASSISTED LIVING  SUMMARY STATEMEN	1808 N CA KANNAPO NT OF DEFICIENCIES T BE PRECEDED BY FULL	B. WING		R 12/22/2014
KANNON CREEK ASSISTED LIVING	STREET ADD 1808 N CA KANNAPO NT OF DEFICIENCIES T BE PRECEDED BY FULL	DRESS, CITY, STAT NNON BOULVA DLIS, NC 28083		
KANNON CREEK ASSISTED LIVING	1808 N CA KANNAPO NT OF DEFICIENCIES T BE PRECEDED BY FULL	NNON BOULVA		
	KANNAPO NT OF DEFICIENCIES T BE PRECEDED BY FULL	ID 1D	RD	
	NT OF DEFICIENCIES T BE PRECEDED BY FULL	ID		
(VA) ID SLIMMARY STATEMEN	T BE PRECEDED BY FULL			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE
D932 Continued From page 150		D932		
-Diagnoses included diabet -An order for FSBS (finger times daily.				
Review of the history of the labeled with Resident #2's 1. The date and time displayed was accurate to the current 1. Two of the FSBS results reglucometer history for Nove FSBS results documented November 2014 Medication Record (MAR).  None of the FSBS results glucometer's history for Def FSBS results documented December 2014 MAR.  FSBS results recorded in thistory were not daily.  Multiple FSBS results were day, and were 3 minutes or the manufacturer's guidelin wipes, the minimum time redisinfecting would be 2 min time for air drying for a total	name revealed: red on the glucometer t date and time. ecorded in the ember 2014 matched on Resident #2's n Administration  recorded in the ecember 2014 matched on Resident #2's the glucometer's re recorded the same r less apart. (Based on ne for the disinfecting equired for proper nutes wet time plus			
Examples of times when m recorded in the glucometer dates were as follows: -On 11/18/14 at 7:01 am, F FSBS=78; and at 5:26 am, -On 12/15/14 at 7:08 am, F FSBS=273; at 7:27 am, FS matched FSBS result for th of another resident); at 7:32 at 10:59 am, FSBS=126.	FSBS=159; at 5:16 am, FSBS=173. FSBS=244; at 7:25 am, GBS=129 (FSBS=129 ne same date and time 2 am, FSBS=211; and			

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-He had resided at the facility for 4 years.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
			B. WING		R
		HAL080003	B. WING		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	1808 N C	ANNON BOULV	ARD	
		KANNAP	OLIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
D932	Continued From page	e 151	D932		
	-Staff checked his blo and if his blood sugar shot. -He had his own gluc	ood sugars three times a day was high, he got an insulin ometer.			
	Refer to interview on 12/17/14 at 11:22 am with a day shift medication aide.				
	Refer to interview on 12/17/14 at 4:20 pm with the Administrator and Assistant Resident Care Coordinator (ARCC).				
	Refer to telephone in am with a night shift r	terview on 12/19/14 at 10:50 medication aide.			
	Refer to interview on the Resident Care Co	12/22/14 at 11:50 am with pordinator (RCC).			
	-A current FL2 dated which included diabe	FSBS checks to be done at			
	#13's labeled glucom following multiple rea minutes apart. The fo	am, results of 218.  om, results of 130.  om, results of 111.  am, results of 159.  am, results of 94.  om, results of 246.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3		X3) DATE SURVEY	
AND PLAN (	AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILD		A. BUILDING: _		COMPLETED
		HAL080003	B. WING		R <b>12/22/2014</b>
			1		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	IG 1808 N CA	NNON BOULV	ARD	
		KANNAPO	LIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D932	Continued From page	e 152	D932		
	3:00 pm revealed: -"They use my own g -"I see them clean it w know what it is""They clean my finge every time".  Refer to interview on day shift Medication A Refer to interview on Administrator and Ass Coordinator (ARCC).  Refer to telephone int am with a night shift M Refer to interview on the Resident Care Co F. Review of Residen -A current FL2 dated which included diabet -A physician order for 7:00 am, 11:00 am ar  On 12/17/2014 at 2:0 #12's labeled glucom following multiple rea minutes apart. The fo	12/17/14 at 4:20 pm with the sistant Resident Care  terview on 12/19/14 at 10:50 Medication Aide.  12/22/14 at 11:50 am with bordinator (RCC).  at #12's record revealed: 1/22/2014 with diagnoses tes.  FSBS checks to be done at and 5:00 pm.  0 pm review of Resident eter revealed a history of the dings that were less than 4 sillowing readings were of diabetic residents other			
		n and staff interviews, it was #12 was not interviewable.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		CONSTRUCTION	(X3) DATE S	
7.1.12 . 12.11 .		is a transfer of the second and the	A. BUILDING: _			
		HAL080003	B. WING		R	2/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE		
		1808 N CA	NNON BOULV	,		
KANNON	CREEK ASSISTED LIVIN	IG .	DLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D932	Continued From page	e 153	D932			
	Refer to interview on day shift Medication A	12/17/14 at 11:22 am with a Aide.				
	Refer to interview on Administrator and Ass Coordinator (ARCC).	12/17/14 at 4:20 pm with the sistant Resident Care				
	Refer to telephone interview on 12/19/14 at 10:50 am with a night shift Medication Aide.					
	Refer to interview on 12/22/14 at 11:50 am with the Resident Care Coordinator (RCC).  Interview on 12/17/14 at 11:22 am with a day shift medication aide revealed: - She performed FSBS checks for residents during her shift She routinely cleaned the residents' glucometer after each FSBS by using the (Brand) disinfecting wipe She stated she used a saturated wipe to wipe the glucometer (front, back and ends) and wrapped the cloth around the glucometer She stated then placed the covered glucometer on top of the medication (on a clean paper towel) for 2 minutes, removed the wipe, and allowed the glucometer to dry for 1 to 2 minutes and either placed it back in the cart or used it on another resident, if needed She was trained in this method of cleaning the glucometers when she started as a medication aide for the facility. (She was not sure which staff					
		sistant Resident Care				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1	5. 05.u.=0.u.		A. BUILDING: _				
		HAL080003	B. WING			R <b>22/2014</b>	
					121	22/2014	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA				
KANNON	CREEK ASSISTED LIVIN	IG .	ANNON BOULV OLIS, NC 28083				
040.45	CLIMMADY CT				AE CORRECTION	0.5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D932	Continued From page	e 154	D932				
D932	- The corporate policy glucometers with proportion of the facility does not place to routinely more in the glucometers for timeframe required or per the disinfectant management of the Administrator and glucometers must be multiple residents by for the facility to share glucometers.  - For residents that disponenters by remove disinfectant wipe, wip wrapping the glucome placing on the medical removing the wipe and air dry.  - The disinfecting prominutes to complete.  - Staff had received the pharmacy nurse for distinct the facility of the training did not recomplete.  - The policy for sharing use for about 2 years.  Interview on 12/22/14 Resident Care Coord	y is that the facility can share per disinfecting. It currently have a system in nitor the FSBS history stored or compliance in the radisinfecting glucometers nanufacturer's guidelines. Ind ARCC were not aware approved for use with the manufacturer in order the ethe glucometer.  In 12/19/14 at 10:50 am with on Aide revealed: supposed to have their own aid not have a glucometer for the trained to disinfect the ing a wet (Brand Name) with the wipe and the plucometer, the eter with the wipe and the ation cart for 2 minutes, and allowing the glucometer to cess required at least 4 training from the consulting disinfecting glucometers but the quire return demonstration.	D932				
	months She was the ARCC	prior to becoming the RCC					
	and assisted an RCC facility.	that was no longer at the					
	- She was not aware	the Brand B glucometer was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL080003	B. WING		R <b>12/22/2014</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON	ODEEK AGGIOTED I NAV	1808 N CAI	NNON BOULV	ARD	
KANNON	CREEK ASSISTED LIVIN	IG KANNAPO	LIS, NC 28083	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D932	- Staff had using the I multiple residents but disinfect the glucome - She was not aware was responsible to che to verify a brand of gl - All diabetic residents glucometer a few more September) but sever glucometers mainly drown as monitoring glucometer checking for staff con glucometers.  The facility provided a 12/17/14 that included - All (100%) glucometer manufactory guidelined - The facility will receion 12/18/14.  Will monitor disinfect with a facility QI tool.  Inserviced Medicating glucometers using redisinfecting glucometer using redisinfecting glucometer. Medication Aides with sugar until in-serviced Resident Care Coor Disinfecting Glucometers using redisinfecting Glucometers.	e only per the manufacturer. Brand B glucometers on thad been trained to ters between residents. The facility (ARCC or RCC) neck with the manufacturer ucometer could be shared. It is had been ordered new noths ago (starting in ral had not received the new use to insurance issues. It is insurance issues. It is insurance with disinfecting and Plan of Protection on the distribution of shared glucometers and it is insurance is insurance with disinfecting the plan of shared glucometers and it is insurance is insurance with disinfecting the plan of shared glucometers and it is insurance is insurance is insurance is insurance with disinfecting and it is insurance in insurance is insurance in insurance is insurance is insurance is insurance is insurance in insurance is insurance is insurance in insurance is insurance in insurance is insurance is insurance in insurance is insurance is insurance in insurance in insurance is insurance in insurance in insurance in insurance is insurance in	D932	DEFICIENCY)	
	meeting to assure sys	reviewed in monthly QI			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
THE PERIOD CONNECTION	BENTI IO/NION NOMBEN.	A. BUILDING:			
		D WING	R		
	HAL080003	B. WING	12/22/2014		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
KANNON CREEK ASSISTED LIVIN	1808 N CAN	1808 N CANNON BOULVARD			

ANNON	CREEK ASSISTED LIVING	ANNON BOULVAF POLIS, NC 28083	RD	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
D932	Continued From page 156	D932		
	updated as needed.			
	CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED February 5, 2014.			
D992	G.S.§ 131D-45 Examination and screening	D992		
	G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.			
	(a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening			
	of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the			
	applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the			
	physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates			
	the presence of a controlled substance, the adult			

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STATEMENT OF DEFICIENCIES (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or dortheorion	IDENTIFICATION NOWIDER.	A. BUILDING: _		
		HAL080003	B. WING		R 12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	G	ANNON BOULV OLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D992		re a second examination fy the results of the prior	D992		
	failed to assure an ex the presence of contr performed for 1 of 7 s	nd record review, the facility amination and screening for			
	The findings are:				
	-Staff G was hired on -Staff G began emplo 4/29/14.	yment at the facility on a personal care aide (PCA). controlled substance			
	PCA revealed: -The Administrator as test sometime in June-She turned her "spec Care Coordinator (RC-She did not know she submitted the controll exam/screening prior Interview on 12/22/14 Administrator revealer-She, along with the R	cimen" in to the Resident CC).  e was supposed to have led substance to being hired.			
	hiresShe thought only me	dication aides were			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL080003	B. WING		R 12/22/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KANNON	CREEK ASSISTED LIVIN	G	NNON BOULV		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D992	supposed to be drug -She had reviewed th	tested prior to hire. e controlled substance test the computer, but could not	D992		

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